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Attitudes of Australian Doctors, Nurses and Community Members Towards Physician-Assisted Suicide and Euthanasia[1] [2]

Abstract

Debate about euthanasia and physician-assisted suicide has been increasing in many countries over recent years, including Australia. Recent Australian studies found support for euthanasia ranging from 33 to 60% for doctors, 38 to 77% for nurses, and 65 to 75% for community members. This paper reports on three large postal surveys, which investigated attitudes of doctors, nurses and community members to a range of end-of-life issues. Results are reported for those questions directly related to medical decisions at the end of life, including physician-assisted suicide and euthanasia. Across the three studies responses to the 38-page questionnaire were received from almost 3000 participants. Response rates ranged from 76% for health professionals in the first study to 50% for community members in the third study. A majority of respondents said that, if asked by a competent patient, doctors or nurses should (a) give additional pain relief even if they believe that this will hasten the patient's death; and (b) turn off a life-support machine. There was strong support from community members for the legalization of physician-assisted suicide/euthanasia, moderate support from nurses, but much less support from doctors. Qualitative data indicated that these are complex issues, requiring further discussion and investigation.

Debate about euthanasia and physician-assisted suicide has been increasing over recent years and include arguments for and against legalization of these actions. An aging population in many countries, increasing health care costs and use of technology to sustain life/prolong dying has added urgency to these debates. Australia, although geographically distant to the United States and Europe where much of the discussion has taken place, has not been isolated from the debates. Australia is a federation of six states and two territories. Health law is the responsibility of each state or territory. However, the territories do not enjoy the same degree of autonomy accorded to the states and their laws are subject to veto by the Federal government. In recent years bills which would

[1] Funding: Study 1 – National Health and Medical Research Council; Study 2: General Practice Evaluation Programme, Commonwealth Government. Co-researchers in these studies were: MA Steinberg and GM Williams (all studies); J Najman (Qld 1 and NT); R Hoffenberg and MJ Clarke (Qld 1); MH Parker and C Del Mar (Qld 2); G Robinson and WB Tyler (NT).

legalize physician-assisted suicide and/or active voluntary euthanasia have been presented to several state and territory parliaments, but have either been rejected by the parliament or have lapsed when an election was called. On 1 July 1996, the Northern Territory of Australia became the first place in the world to enact legislation which allowed both physician-assisted suicide and euthanasia (the *Rights of the Terminally Ill Act (1995)* (ROTI)). The legislation was subsequently overturned by the Federal Government in March 1997, with the *Euthanasia Laws Act.* (Note: Had the legislation been passed by one of the states, the Federal government could not have overturned it).

Studies on attitudes and practices

A number of studies undertaken in Australia during the past decade assessed attitudes to physician-assisted suicide and/or euthanasia.[1-13] (Table 1). Support for euthanasia ranged from 33 to 60% for doctors,[1,4,6-12] and 38 to 77% for nurses.[3,5,6,12,13] Support from patients or community members for legislation allowing physician-assisted suicide and euthanasia ranged from 65 to 75%.[6,9,12] In 1991, Owen, Tennant and colleagues found that, of 105 oncology patients interviewed at a major teaching hospital, 'one third ... anticipated some role for taking active steps to end their own lives'. In addition to these studies, Morgan Gallop Polls, repeated regularly in Australia since 1962, have shown increasing community support for legalizing euthanasia (from 47% in 1962 to 76% in 1996).[14]

In their 1987 study of Victorian doctors, Kuhse and Singer[1] found that 40% had been asked to hasten death, 29% had taken active steps to bring about the death of a patient who had asked them to do so (the majority on more than one occasion), and 93% of doctors who had been asked for assistance to die considered that such requests are sometimes rational. In their study of Victorian nurses in 1991,[3] it was found that 55% of respondents had been asked by patients for assistance to end their lives either by permitting the patient to forego life-sustaining measures or by active assistance to end life. Only 5% said that they had complied with the request without having been asked by a medical practitioner to do so.

In both studies the main reasons for such requests were persistent and unrelievable pain and terminal illness and infirmities of old age, with terminal cancer being the medical condition most often mentioned. Fifty nine percent of the doctors and 75% of the nurses thought that it would be a good thing if Australia had a system such as exists in the Netherlands; 60% of doctors and 78% of nurses thought that the law should be changed to allow doctors to take active steps to bring about a patient's death under some circumstances, and 40% of doctors and 65% of nurses said that they would be willing to be involved in active voluntary euthanasia if it were legal.

When Baume and O'Malley repeated the Kuhse and Singer study with doctors in New South Wales in 1993[4] they found that almost half of the 1268 respondents had been asked to perform euthanasia, of whom 28% had complied, and there was majority support for changes to the law.

The use of specific scenarios to determine doctors' practices was the method employed by Waddell and colleagues in 1996.[8] They requested doctors to select from a range of treatment options for specific patients and conditions; for instance, one scenario described a 56-year old man with motor neurone disease who requested

Table 1. Australian research on attitudes to physician-assisted suicide and euthanasia.

Year	Researchers	Subjects (n)	Response rates (%)	Support for change of law (%)	Other positive responses (%)
1987	Kuhse and Singer	2000 Victorian doctors	46	60	
1991	Owen, Tennant and colleagues	105 New South Wales oncology patients	63		34
1991	Kuhse and Singer	1942 Victorian nurses	49	78	
1993	Baume and O'Malley	1945 New South Wales doctors	65	58	
1994	Aranda and O'Connor	380 Victorian palliative care and oncology nurses	45	50	
1994	Steinberg, Cartwright and colleagues	1092 Queensland public; 277 Queensland doctors, 569 Queensland nurses and 14 other palliative care staff	53 76	65 43	
1995	Hassan	494 South Australian doctors	60	44	
1995	Waddell, Clarnette and colleagues	2172 doctors across Australia	73	NA	15
1996	Steinberg, Parker, Cartwright and colleagues	581 Queensland patients; 287 Queensland family physicians	67 60	65 33	
1996	Wilson, Kay and Steven	1108 family physicians across Australia	80	56	
1996	Kuhse, Singer and colleagues	3000 doctors across Australia	64	NA	30
1997	Cartwright, Robinson and colleagues	1069 Northern Territory public; 343 Northern Territory doctors 415 Northern Territory nurses	50 51 59	75 35 66	
1997	Kitchener and Jorm (Scenarios)	2000 Australian Capital Territory nurses	61	38-71	

NA, not asked

physician-assisted suicide. Only 14% of respondents indicated that they would provide physician-assisted suicide or euthanasia for this patient, while 84% would provide palliative care only. Scenarios presented to nurses in the Australian Capital Territory by Kitchener and Jorm in 1997[13] found that, among approximately 1200 nurses who responded, 38% supported a change in the law to allow active voluntary euthanasia for a young man with AIDS, 39% for an elderly man with early stage Alzheimer's disease, 44% for a young woman who had become quadriplegic, and 71% for a middle-aged woman with metastases from breast cancer.

In 1996, Kuhse and colleagues[11] found that 800 of 1918 responding doctors had made end-of-life decisions for patients, that 26 said that they had performed euthanasia, and that 51 reported ending the patient's life without the patient's explicit request. The proportion of all Australian deaths that involved a medical end-of-life decision were: euthanasia, 1.8% (including physician-assisted suicide, 0.1%); ending of a patient's life without this patient's concurrent explicit request, 3.5%; withholding or withdrawing of potentially life-prolonging treatment, 28.6%; alleviation of pain with opioids in doses large enough that there was a probable life-shortening effect, 30.9%. In 30% of all Australian deaths, a medical end-of-life decision was made with the explicit intention of ending the patient's life, of which 4% were in response to a direct request from the patient. Overall, Australia had a higher rate of intentional ending of life without the patient's explicit request than the Netherlands.

The Queensland and Northern Territory Studies

Between 1994 and 1997 three studies were undertaken by researchers from the University of Queensland to assess the attitudes of doctors, nurses and the general community to a range of issues relating to end-of-life decision making. Two of the studies were conducted in Queensland[6,9] and one in the adjoining Northern Territory.[12] Two researchers from the Northern Territory University joined the research team for the latter study. Throughout this paper the studies will be referred to as Qld 1, Qld 2 and NT. The NT study was conducted while the ROTI Act was still in force.

Questionnaire development

Using data from focus groups and key informant interviews with representatives of medical, nursing, ethics, legal, general and older community groups and additional information from the relevant literature, three base-line questionnaires were developed (medical, nursing and community) (Qld 1). To ensure that questions were not biased, each question had to pass an advisory committee in which members' attitudes towards physician-assisted suicide and euthanasia were widely disparate. Emotive terms such as 'intolerable pain' or 'unbearable suffering' were avoided. The questionnaires were piloted, and slight amendments made for specific professional or age groups.

Additional interviews were held with family physicians and patients for Qld 2 study and with Northern Territory health professionals and community members for the NT study. Questionnaires from Qld 1 were amended as necessary for the subsequent studies. Topics covered in the questionnaires included advance directives, enduring power of attorney for health matters, doctor-patient communication, pain management, palliative care, physician-assisted suicide, euthanasia, legal and administrative matters and demographics (34-40 page questionnaires).

Sample Selection

Qld 1 study

- The health professional sample included the Director of Nursing of every nursing home in Queensland, two groups of community nurses, all members of the Queensland Critical Care Nurses Association, all members of the Queensland Palliative Care Association, two groups of family physicians, all Brisbane-based members of the Australian Society for Geriatric Medicine, and 10% each of the Brisbane membership of the Colleges of Physicians, Surgeons, Anesthetists and Psychiatrists, randomly sampled from lists provided by the Colleges (total n = 1184). After deleting those who were overseas, had left the profession or were included in more than one database, the final eligible sample was 1129.
- For the community, a stratified random sample of 1100 was drawn from the 1995 Queensland Electoral Role. As these issues are considered to be of greater concern to older people, 700 of the sample were aged 60 and above, stratified by age and sex to match the Queensland 1991 Census. Eight of the 1100 were in a nursing home, leaving a final eligible sample of 1092.

Qld 2 study

- 305 family physicians from Brisbane (n = 241) and Toowoomba, a large rural city (n = 64), were randomly sampled from all family physicians in those areas who had a consultation rate of 3000 or more in the previous year. Of these, eighteen were overseas, deceased, interstate or no longer practicing, leaving a final eligible sample of 287.
- From a random sample of 31 of the 172 family physicians who returned questionnaires, 626 patients who had been seen in the previous twelve months were randomly sampled from appointment records. Of these 45 were non-contactable, too ill or frail, deceased or under eighteen, leaving an eligible sample of 581 patients (Brisbane, n = 348; Toowoomba, n = 233).

NT study

- All medical practitioners registered in the Northern Territory, with the exception of those known to be radiologists or pathologists, were included in the sample (n = 480). Of these, 137 were no longer in the Northern Territory, not at the address given, overseas, interstate or had left the profession, leaving an eligible sample of 343. (Note: in the Northern Territory living conditions are sometimes quite difficult and the population is particularly mobile. It also tends to have a more transient health professional population).
- From the approximately 2000 nurses registered in the Northern Territory at 1 July 1996, 448 were randomly sampled. Of these, 33 were no longer living in the Northern Territory or not at the address given, or were no longer nursing, leaving an eligible sample of 415.
- The Commonwealth Electoral role for the Northern Territory was used as the sampling frame for the community sample. As the use of questionnaires was consid-

ered an inappropriate method for data-collection with the Aboriginal community, remote areas of the Northern Territory were not included in the study. A random sample, stratified by area and age, resulted in the selection of 1298 community members. Of these, 229 were not contactable, too ill or frail, spoke insufficiently English or were deceased, giving a final eligible sample of 1069. (Note: the mobility of the population made it impossible to accurately determine how many of the remaining sample actually received their questionnaires, but they remained in the base-line total).

Definitions

The following definitions were used in the 3 studies:

Palliative care does not aim to cure patients but aims to care for them, physically keeping them as comfortable and pain-free as possible, while also attending to their emotional, mental, social and spiritual needs. Palliative care also includes caring for the patient's family and/or significant others, including during the time following the death of the patient.

Persistent vegetative state: a person will be considered to be in a persistent vegetative state (PVS) if, over a period of not less than twelve months there has been no return of cognitive, behavioral or verbal responses, no purposive motor responses or other evidence of voluntary motor activity; appropriate clinical and investigative diagnosis has been undertaken, and the diagnosis of PVS is based on repeated observation by the physician responsible for the care of the patient.

Physician-assisted suicide refers to such things as the physician giving a person advice about how to commit suicide, giving the person a prescription for medication to use for suicide, preparing a mixture for the person to take to commit suicide and/or setting up equipment for the person to use to commit suicide. It does *not* include performing the action, such as giving the person an injection of the drugs.

Euthanasia means taking active steps to end the life of another person, at that person's request, for what they see as their best interests. Active euthanasia refers to an action such as giving the person an injection of medication sufficient to cause the death of that person.

Response rates

Across the three studies responses to the 38-page questionnaire were received from almost 3000 participants. Response rates [6(b), 9, 12(b)] ranged from 76% for health professionals in Qld 1 to 50% for community members in the NT study (Table 1). The age distribution of community members was similar in Qld 2 and NT; Qld 1 had more older respondents because of the sampling process.

Results

The studies asked questions about a range of end-of-life issues, from advance health directives and enduring power of attorney, through pain management and palliative

care to physician-assisted suicide and euthanasia. Results are reported in this paper only for those questions directly related to medical decisions at the end of life, including physician-assisted suicide and euthanasia.

Pain relief in terminal illness

Participants in all three studies were asked the following question: '*It is recognized that using large doses of morphine may hasten a person's death. If a terminally ill patient requests extra medication to control pain should the doctor give the medication, even if they know that this will hasten the patient's death?*' Participants were also asked if the nurse should give the medication if it has been ordered p.r.n. A majority of respondents in all three studies said 'yes' to these questions (Table 2).

Stopping life support for a competent patient

Participants in all three studies were asked: '*If a competent person is being kept alive by a life support system (such as a respirator) and that person asks for the machine to be turned off, do you think the doctor should comply with that request?*' A majority of respondents in all studies said that doctors should turn off the machine when asked to do so by a competent person. Those who did not say 'yes' to this question were more likely to say 'not sure' than to say 'no' (Table 2). Nurses were more likely than doctors to say 'yes' to this question.

Table 2. Should a doctor or nurse give extra morphine, or should a doctor switch off the machine, at the request of a competent terminally ill patient?

	QLD 1		QLD 2		NT	
	Health professionals (n = 821) % replying 'yes'	Community members (n = 475) % replying 'yes'	Family physicians (n = 168) % replying 'yes'	Patients (n = 379) % replying 'yes'	Health professionals (n = 407) % replying 'yes'	Community members (n = 522) % replying 'yes'
Doctor should give morphine	96	85*	94	91	95	87
Nurse should give morphine	91	*	80	74	88	71
Doctor should switch off machine	(n = 847) %	(n = 475) %	(n = 167) %	(n = 382) %	(n = 406) %	(n = 529) %
Yes	65	72	56	72	58	71
No	9	10	14	11	12	13
Not sure	26	18	30	17	30	16

* Combined question: 'should doctor/nurse give the medication?'

Persistent vegetative state

Health professionals in Qld 1 and the NT study and community members in the NT study were asked: '*If a patient has been in a persistent vegetative state for more than twelve months, should (a) artificial respiration be stopped?; (b) artificial nutrition be discontinued?; and (c) artificial hydration be discontinued?*' There was very strong agreement from all three groups that artificial respiration should be discontinued (Qld 1 health professionals, 93%; NT health professionals, 89%; NT community members, 87%). For artificial nutrition the agreement was 75%, 72% and 75%, respectively. Although 76% of the NT community members also said that artificial hydration should be discontinued, there was less agreement about this among the health professionals with 61% for Qld 1 and 59% for the NT study. In both Qld 1 and the NT, nurses were less likely than doctors to say that these options should be discontinued, and in Qld 1 this difference was significant.

Physician-assisted suicide

There is often confusion, particularly in the general community, about the difference between physician-assisted suicide and euthanasia. In these studies the terms were clearly defined and participants in all three studies were then asked: '*If a terminally ill person has decided that his life is of such poor quality that he would rather not continue living, do you think a doctor should be allowed by law to assist such a person to die?*' The majority of respondents in the three studies said 'yes' to this question. In Qld 1 and the NT study, health professionals were more likely to say 'yes' than 'no'; however, these two groups included nurses who were more likely than doctors in both studies to say 'yes'. In the Qld 2 study, family physicians were much more likely to say 'no' than 'yes' (Table 3).

Active voluntary euthanasia

In the two Queensland studies participants were asked '*Do you think the law should be changed to allow active voluntary euthanasia for terminally ill people who decide that they no longer wish to live?*' (Note: this question made no mention of pain or suffering). Community members' and patients' responses were very similar in both studies (Table 3) with 65% in both cases supporting a change in the law. Again family physicians (Qld 2) were the least supportive of this option, with more family physicians saying 'no' than 'yes'. In the Qld 1 study, more health professionals said 'yes' than 'no' to the option of changing the law. However, this study included nurses, and for this question critical care nurses were much more likely to support a change in the law, with 61% in favor of doing so; 50% of the Directors of Nursing of nursing homes also supported a change in the law.

As the *Rights of the Terminally Ill Act* was still in operation in the Northern Territory at the time the study was conducted there, the question asked in the Queensland studies did not apply. Participants were therefore asked: '*To what extent do you approve of the law that was recently passed in the Northern Territory which allows a terminally ill person to request physician-assisted suicide or euthanasia?*'.

Table 3. Should a doctor be allowed by law to assist a terminally ill patient to die, and should the law be changed to allow active voluntary euthanasia for terminally ill people?

	QLD 1		QLD 2		NT	
	Health professionals (n = 844) %	Community members (n = 487) %	Family physicians (n = 166) %	Patients (n = 384) %	Health professionals (n = 414) %	Community members (n = 531) %
Should doctor assist patient to die?						
Yes	43	60	30	62	59	73
No	34	23	49	21	27	18
Not sure	23	17	21	17	14	9
Should law be changed to allow euthanasia?	(n= 848) %	(n = 481) %	(n = 168) %	(n = 384) %	(Not applicable – law had been changed in NT)	
Yes	43	65	33	65		
No	36	19	48	21		
Not sure	21	16	19	14		

Responses were on a five-point scale from 'strongly approve' to 'strongly disapprove'.

Of the community members, 75% either strongly approved or approved of the new legislation, 18% disapproved or strongly disapproved and 7% neither approved nor disapproved; for health professionals 53% either strongly approved or approved, 31% disapproved or strongly disapproved and 16% neither approved nor disapproved. However, once again it was the responses of nurses that impacted on these figures, with 66% strongly approving or approving of the legislation, compared with only 35% of the doctors.

Qualitative data from the studies illustrated the complexity of professional and community responses. For instance, two doctors in the NT study who marked the 'strongly disapprove' option for attitude to the ROTI law, wrote: (1) 'I'm not opposed to euthanasia. I just don't think we should hand such a can of worms to lawyers and bureaucrats'; and (2) 'I've been helping my patients with this for years but we don't need a law about it'. They *strongly disapproved* of the legislation, but not necessarily of euthanasia per se. One Northern Territory community member who *strongly approved* of the ROTI law said: 'Tell the Federal Government to keep out of our business', adding further uncertainty to the analyses, as it was unclear whether Northern Territory community respondents approved of a law allowing euthanasia, or simply supported their right to pass such a law.

Younger community members in the Qld studies were the most likely to support physician-assisted suicide and euthanasia. As the Qld 1 study had been over-sampled for older people, community responses in this study were weighted to reflect the actual age composition of the population, resulting in an increase in support for

physician-assisted suicide from 60 to 65% after weighting, and from 65 to 70% for euthanasia. In the NT study, respondents over 60 were somewhat less likely than those under 60 to support both options, but responses were not age-linear: in both cases those aged 30 to 39 were the most likely to support both physician-assisted suicide and euthanasia.

Palliative care and pain management

As opponents of physician-assisted suicide and euthanasia frequently claim that good palliative care and pain management would obviate the need for these options, optimal palliative care was defined and participants were asked two questions: in the two Queensland studies they were asked (1) '*If good palliative care were freely available to everyone who needed it, do you think anyone would ever ask for assistance to end their lives?*', and (2) '*If it were always possible to control a person's pain, in a terminal care situation, do you think anyone would ever ask for euthanasia?*'.

Respondents in both studies said that people would still ask for assistance to end their lives, even if good palliative care were freely available and that people would still ask for euthanasia even if pain could be controlled (Table 4). Health professionals and family physicians were more likely to say 'yes' to these questions than community members and patients were.

Table 4. If good palliative care were freely available would anyone ever ask for assistance to die, and if pain were controlled would anyone ever ask for euthanasia?

	QLD 1		QLD 2	
	Health professionals (n = 840) %	Community members (n = 471) %	Family physicians (n = 170) %	Patients (n = 378) %
With good palliative care, would anyone ask for assistance to die?				
Yes	70	68	72	62
No	30	32	28	38
If pain were controlled would anyone ask for euthanasia?	(n = 849) %	(n = 479) %	(n = 170) %	(n = 386) %
Yes	61	45	65	46
No	20	30	22	29
Not sure	19	25	13	25

These two questions received some criticism, particularly from health professionals, because of the 'do you think *anyone* would *ever*...' wording and were therefore amended in the NT study, as follows: (1) '*If good palliative care were freely available to everyone who needed it, approximately what percentage of patients do you*

think would still ask for assistance to end their lives?', and (2) *'If it were always possible to control a person's pain, in a terminal care situation, approximately what percentage of patients do you think would request euthanasia?'*.

Only 8% of both health professionals and community members said that no-one would ask for assistance to end their lives and only 9% of health professionals and 13% of community members thought that no-one would ask for euthanasia. However, community members were significantly more likely than health professionals to believe that more than 20% of patients in each case would ask (Table 5).

Table 5. Palliative care and pain control (NT study only).

	n	None	1-5	6-10	11-20	21-50	>50
With good palliative care what percentage of patients would ask for assistance to die?							
Health professionals	389	8	43	16	13	13	7
Community members	411	8	16	13	12	22	29
With good pain controle what percentage of patients would ask for euthanasia?							
Health professionals	394	9	48	17	14	7	5
Community members	491	13	20	16	16	19	16

Religion and religiosity

Religion is thought to significantly impact on attitudes towards physician-assisted suicide and euthanasia. In these studies, health professionals who were Catholic were most likely to disapprove of euthanasia and physician-assisted suicide; those who said they had no affiliation were most likely to approve of these options. For community members, extent of religious beliefs rather than religious affiliation predicted their responses, with those who said that their religious beliefs influenced them a great deal most likely to disapprove of physician-assisted suicide and euthanasia, and those whose religious beliefs influenced them not at all most likely to approve of these options.

Doctor-patient relationship

Concern is also sometimes expressed that if euthanasia becomes a legal option it would negatively impact on doctor-patient relationships: most respondents in these studies did not think that laws allowing physician-assisted suicide and euthanasia would harm the trust between doctors and patients; most thought that such laws would open up discussion of end-of-life issues between doctors and patients.

Conclusion

In Australia there is broad health professional and community support for some medical decisions at the end of life, that is, providing adequate pain relief to patients even if that subsequently hastens the patient's death; withdrawing life-support systems when a competent patient requests this; withdrawing artificial ventilation and nutrition from a patient who has been in a persistent vegetative state for at least twelve months. There was slightly less support, although still majority support, for withdrawing artificial hydration.

There is strong support among community members for legislative change to allow physician-assisted suicide and active voluntary euthanasia. However, health professionals were divided on the matter; nurses are more likely to favor such change while the majority of doctors are opposed to it. The qualitative data highlighted the fact that simple 'yes' or 'no' responses to questions on such complex issues may be misleading. Those who oppose euthanasia legislation may not be anti-euthanasia. Similarly, some who support such legislative change may be following other agendas. It would also be too easy to portray doctors who oppose such actions as paternalistic or not wanting to relinquish control of end-of-life decisions to patients; or to portray nurses as more compassionate, with better understanding of patient and family needs. However, further analysis of the qualitative data in these studies suggested that many doctors have deep concern for the well-being of patients, and of the wider community, and believe that legislation allowing physician-assisted suicide and euthanasia is fraught with difficulties, especially for older people who may be seen (or see themselves) as a burden.

Important research questions

Further in-depth research is required to understand 'the attitudes behind the attitudes' expressed in these studies. The research team has secured funding to carry out such research. Questions to be addressed include:

1. What factors, other than religious beliefs, influence attitudes to euthanasia and physician-assisted suicide?
2. What do health professionals and the general community understand the terms 'euthanasia' and physician-assisted suicide' to mean?
3. Would legalizing physician-assisted suicide and euthanasia lead to more, or fewer instances of these actions?
4. What are the attitudes and concerns of indigenous Australians? There is a serious lack of data in this area.

More research is required in Australia with terminally ill people. Although a small amount has been done,[2] there are major practical and ethical constraints on discussing such matters with those who are terminally ill. To address concerns that allowing active voluntary euthanasia will create a 'slippery slope' leading to non-voluntary or involuntary euthanasia, accurate figures are required about the current rate

of physician-assisted suicide and euthanasia in Australia and the number of patients who currently want these options but are unable to access them. There are two barriers to obtaining such information: firstly, as these actions are illegal many health professionals and community members will be reluctant to acknowledge their involvement in them, even where confidentiality is assured; secondly, confusion exists in the minds of many people about what is, or is not, euthanasia. Some respondents in our studies said that they had been involved in euthanasia but their description of the event made it clear that what they thought was euthanasia was not.

International collaboration in such research will help to ensure that terminology and methods are consistent, and will also avoid duplication of research efforts. The National Health and Medical Research Council in Australia encourages researchers to collaborate across disciplines and locations.

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