**Perception and attitude towards Passive Euthanasia among doctors in a tertiary care hospital in North-East India: A Cross Sectional study**

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**Abstract**

**Background:** Debate on euthanasia has been raging for more than half a century around the world and it continues to raise important questions in medical ethics, moral theology, civil rights and liberty. Passive euthanasia involves withholding of medical treatment or withdrawal from life support system for continuance of life. There is a need for the medical people, the public and the legislators to come together, debate and find common ground as preparation for the future of passive euthanasia in the country.

**Objective:** To determine perception and attitude towards passive euthanasia and to evaluate the association between attitude and to document variables favourable to passive euthanasia.

**Methods:** A cross-sectional survey of 673 doctors working at a tertiary care hospital in Manipur was carried out using a self-administered questionnaire. Chi square test was used to assess factors favoring attitudes toward passive euthanasia.

**Results:** Majority of the respondents (80.2%) supported the concept of passive euthanasia. Relief from unbearable pain and suffering were more common (71.8%) reasons for considering passive euthanasia. Majority (78.4%) felt that there should be strict legislation regulating passive euthanasia procedures because it could easily be misused. There was no significant association between sex, religion, specialisation, ICU experience and attitude towards passive euthanasia.

**Conclusion:** The study concluded that majority (80.2%) of the respondents had positive attitude towards passive euthanasia and that there was no significant association between sex, religion, specialisation, ICU experience and attitude towards passive euthanasia. With the increasing numbers of patients needing life support measures and palliative care, it is essential to obtain views of a larger representative population to understand better about euthanasia.

**Keywords:** Passive Euthanasia, attitude, doctors

**Introduction:** The term euthanasia is derived from the Greek words that literally mean “good death” (Eu = Good; Thanatos = Death). The term was coined by the great historian Suetonius who described the way King Augustus opted for quick, painful death without suffering.[1] Euthanasia can be categorized into two types- (a) Active Euthanasia- when a person directly and deliberately does something, which results in the death of patient and (b) Passive Euthanasia- withholding of medical treatment or withdrawal from life support system for continuance of life (like removing the heart-lung machine from a patient in coma).[2,3]

People around the globe have diverse opinion regarding acceptance and understanding the concept of euthanasia. Debate on euthanasia has been raging for more than half a century around the world and it continues to raise important questions in medical ethics, moral theology, civil rights and liberty. Although usually carried out on the ailing person's request, the decision may be taken by relatives, doctors, or in some instances – as in the recent landmark judgement on Aruna Shanbaug – the courts. Since the doctors play a pivotal role in decision making for passive euthanasia, their perception and attitude towards passive euthanasia should include social, ethical, legal and medical aspects.

Earlier studies in India conducted among doctors in New Delhi and South India have shown that majority of doctors supported the concept of passive euthanasia.[4,5] Studies were lacking in North-East India. The present exploratory study was conducted at a tertiary care hospital in North-East India with the objectives to determine the perception and attitude towards passive euthanasia among doctors and to document variables favourable to passive euthanasia.

**Materials and Methods:** A cross-sectional survey was conducted between October 2014 and September 2016 among doctors in RIMS, Manipur. The study included all post graduate medical students(clinical/non-clinical) who joined RIMS during the academic year 2012-2013; 2013-2014; 2014-2015 and RIMS doctor employees on payroll which was 673, therefore sample size calculation and sampling was not done. Those who could not be contacted even after three consecutive visits and those who refused to participate were excluded. Age, sex, religion, marital status, educational qualification, area of specialization, designation, ICU experience were the predictor variables whereas attitude regarding passive euthanasia was the outcome variable.

**Study Instrument:** A self-administered questionnaire was designed and was examined and approved by three specialists with expertise in palliative care and medical ethics. The schedule consisted of the following parts:

* Section A pertained to the background information of the participants
* Section B had 13 statements that recorded the attitude of the participants towards passive euthanasia. The responses to each statement were scored on a 5-point Likert scale ranging from strongly disagree (-2) to strongly agree (+2). The statements included 11 positively keyed items and 2 negatively keyed items(reverse scoring). Maximum and minimum obtainable score was +26 and -26 respectively. A overall positive score reflected a positive attitude and overall negative score indicated a negative attitude and score zero for neutral attitude
* Section C had 6 statements that described what had to be done before the act of passive euthanasia on a terminally ill patient
* Section D had 12 questions dealing with the factors influencing decision making in passive euthanasia

**Operational definition:** Passive euthanasia occurs when the patient dies because the medical professionals either don't do something necessary to keep the patient alive, or when they stop doing something that is keeping the patient alive (eg. switch off life-support machines, do not resuscitate, starve to death, disconnect a feeding tube, don't carry out a life-extending operation, don't give life-extending drugs).

**Data collection:** The questionnaires were given to RIMS doctors on payroll and postgraduate trainees of clinical and non-clinical specialities during work hours. The filled-in questionnaires were returned to the investigator within a day. Data collected was sorted and checked for completeness and consistency. Data were analysed using SPSS (IBM) version 21.0. Data were summarized using descriptive statistics. Chi-square test was used to assess the association between background characteristics and other variables with attitudes. P value <0.05 was considered as significant. Approval was obtained from the Institutional Ethics Committee before the beginning of study. Informed consent from all the participants was obtained. Confidentiality was maintained. Data were kept safely in the investigator’s locker and could be accessed only by the research team.

**Results:** Out of the total 673 eligible participants, questionnaires were distributed to 627 doctors and 577 returned back their responses giving a response rate of 85.7%. Table 1 shows that 68.3% of the respondents were males. Age of the respondents ranged from 24 years to 63 years with a mean of 37.1 ± 10.7 years. Of the respondents, 77.3% felt that physicians should initiate the discussion about passive euthanasia on a terminally ill patient and 59.3% felt that hospital ethics committee need to be consulted when making decisions about passive euthanasia. None of the respondents got any request for passive euthanasia in their practice so far.

Table 2 shows that about half of the respondents disagreed that withdrawal of life sustaining treatment in the case of passive euthanasia is same as murder. Majority (78.4%) agreed that there should be strict legislation regulating passive euthanasia procedures. Overall mean score of all the respondents was 5.63 and the maximum and minimum score obtained were 22.0 and -13.0 respectively. Of the respondents 80.2% had positive attitude, 2.9% neutral attitude and 16.9% had negative attitude towards passive euthanasia.

Table 3 shows that 94.1% of the respondents agreed that declaration from patient/ family members must be obtained before the act of passive euthanasia and 3/4th agreed that withholding and withdrawing treatment in case of passive euthanasia are ethically the same.

Table 4 shows that majority of the respondents felt that quality of life as viewed by the patient, family member/patient request, patient unlikely to survive because there are not much alternative treatments and financial costs to patient/family were the important factors in influencing decision making regarding passive euthanasia on a terminally ill patient.

Table 5 shows that there is no significant association between sex, age, and marital status, religion, working category, specialization, ICU experience and attitude towards passive euthanasia.

**Discussion**

This study showed that the concept of passive euthanasia is acceptable to a large section of doctors (80.2%) in a tertiary care hospital in North Eastern India. This could be due to the fact that these professionals were in close association with issues pertaining to euthanasia in their day-to-day work. Furthermore, world wide acceptance of passive euthanasia may be noted in response to a questionnaire as in this study, but the support is likely to decrease when physicians actually encounter the situation in reality and that being in favour of passive euthanasia does not suggest willingness to actually perform passsive euthanasia in the event that it was legalized.[6]

A study in New Delhi found that a majority of physicians found withholding or withdrawal of treatment acceptable.[4] Earlier studies[7,8] from India reported different results with most doctors who were surveyed strongly opposing euthanasia. However, Hagelin et al[9] found that the phrasing of the questions may have affected the results as evidenced from the fact that in this study the questions were pointed towards passive euthanasia specifically.

In a study by Kamath et al[5], 57.1% agreed that patients who are terminally ill should be allowed to die with dignity and 23.8% agreed that medical resources should be made available for those who need, whereas in this study 63.8% of the respondents agreed that patients who are terminally ill should be allowed to die with dignity and 61.7% agreed that ICU bed availability will be a decision making factor while considering passive euthanasia. In this study, 71.8% of the respondents agreed that terminally ill patient should receive drugs to relieve pain and suffering, even if these drugs may hasten the end of the patient’s life which was similar to Gielen et al[4] findings that physicians working in palliative care in Delhi favoured the practice of painkillers such as morphine and palliative sedation to keep the patient comfortable. This shows that attitude of doctors towards various components of euthanasia varies with their training and their experience of caring in for terminally ill patients.

In the study, majority (80.2%) of the respondents had positive attitude regarding passive euthanasia as compared to Kamath et al[5] (69.3%). Among those with positive attitude, majority felt that it is cruel to prolong the intense suffering of a terminally ill patient (63.5%) and there should be strict legislation to perform passive euthanasia on a terminally ill patient (81.7%). Among those who had negative attitude, more than half felt that passive euthanasia could be considered same as murder and that legislation of passive euthanasia may lead to less aggressive treatments when compared to Kamath et al[5] (66.2%) and Subba et al[10] (37.4%) felt that if euthanasia was legalized in India it could be misused by medical professionals. The study pointed out that physical suffering and financial burdens were patients’ factors that need to be considered while performing passive euthanasia. Similarly, the reasons given for not justifying passive euthanasia were related to the legal and ethical dilemmas they face. These reasons were similar to findings reported by Subba et al.[10]

In this study, no association was found between age, sex and being in favor of the concept of passive euthanasia, similar to previous studies.[5,11,12,13,14] This may be due to the fact that the knowledge gained by medical curriculum at young adulthood might have influenced their perception towards passive euthanasia and might be unchanged over years. Also in this study, majority (70.7%) of the respondents were aged 24-40 years and younger generation of Indian doctors might be more open and receptive to the idea of passive euthanasia.

In the study 70.1% felt that religious belief had no influence on their attitude regarding passive euthanasia whereas in a study by Kamath et al[5] (75.9%) had similar opinion. In this study there was no significant association between religion and attitude towards passive euthanasia in contrary to other studies[5,7,15,16,17,18] which showed that religious belief have significant association with views on euthanasia. This could be due to the fact that doctors irrespective of religion, might be of the opinion that, assisting in ending a painful life is performing a good deed and hence fulfilling their moral obligation. On the contrary, studies[20,21]  showed that many Islamic scholars agreed that curative or life sustaining treatment ought not to be forgone.

In this study, there was no significant association between area of specialisation and attitude towards passive euthanasia in contrary to study done by Emanuel et al[6] which found doctors in certain specialties to be more in favor of euthanasia, and studies[11,22,23,24] found palliative care specialists, oncologists, and geriatricians were less willing to actively hasten a patient's death.This may be related to their chances of encountering number and severity of terminally ill patients in their practice.

The study results were similar to the findings of previous studies[10,16] which showed that there was no significant association between marital status and attitude regarding passive euthanasia. This may be because marital status did not influence the doctor-patient relationship.

This survey focused on passive euthanasia in all dimensions compared to other surveys in India, which did not make a clear distinction between active and passive euthanasia. The study respondents were doctors from various specialities who were directly or indirectly related to decision making about euthanasia which adds an edge over other studies. One of the key limitations was that, since this study relied on self-reported responses, there was no objective way to know whether the perception of passive euthanasia remains unchanged when they actually face the situation in reality. Another limitation was that the study did not explore other areas of relevance such as patients’ and family members’ perceptions. In addition, the study was done among doctors from one institution only and this somewhat restricts the generalization of the results to the whole doctor population in India.

**Recommendation:** With the increasing numbers of patients needing life support measures and palliative care, it is essential to obtain views of a larger representative population to understand better about passive euthanasia.

**Conclusion:** Majority of the doctors had positive attitude towards passive euthanasia. sex, religion, area of specialisation and ICU experience did not influence their attitude towards passive euthanasia.

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**Tables**

**Table 1: Background characteristics of the respondents (N=577)**

|  |  |  |
| --- | --- | --- |
| **Variable** | **Frequency** | **Percent** |
| **Sex** | | |
| Male | 394 | 68.3 |
| Female | 183 | 31.7 |
| **Age (years)** | | |
| 24-40 | 408 | 70.7 |
| >40- 63 | 169 | 29.3 |
| **Religion** | | |
| Hindu | 463 | 80.2 |
| Christian | 96 | 16.6 |
| Islam | 11 | 1.9 |
| Others | 7 | 1.3 |
| **Consider yourself religious** | | |
| Yes | 515 | 89.3 |
| No | 47 | 8.1 |
| Not sure | 15 | 2.6 |
| **Designation** | | |
| Post graduate trainee | 368 | 63.8 |
| Faculty | 209 | 36.2 |
| **ICU experience** | | |
| Yes | 106 | 18.4 |
| No | 471 | 81.6 |
| **Passive Euthanasia means\*** | | |
| Withholding/withdrawing life saving treatment | 308 | 53.4 |
| Mercy Killing | 161 | 27.9 |
| Painless killing | 87 | 15.1 |
| Others† | 21 | 3.6 |
| **Discussion about Passive Euthanasia to be initiated by** | | |
| Physicians | 446 | 77.3 |
| Nurses | 7 | 1.2 |
| Family | 69 | 12.0 |
| Patient | 55 | 9.5 |
| **Who needs to be consulted when making decisions about passive euthanasia on terminally ill patients\*\*?** | | |
| Hospital legal representatives | 237 | 41.1 |
| Hospital ethics committee | 342 | 59.3 |
| Patient | 307 | 53.2 |
| Family | 236 | 40.9 |
| Other clinicians from within the unit | 170 | 29.5 |
| Clinicians outside the unit | 169 | 29.3 |

\*open ended question. Responses were coded into three domains

† making life less miserable, rest in peace etc

\*\*percent do not tally to 100 as multiple responses were allowed

**Table 2: Response to questions that determine the attitude regarding Passive Euthanasia (N=577)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| S.No | **Statement** | Strongly disagree  n(%) | Disagree  n(%) | Not sure  n(%) | Agree  n(%) | Strongly agree  n(%) |
| 1 | Passive euthanasia is an act of mercy and allows patient who is terminally ill to die with dignity | 155(26.9) | 24(4.2) | 30(5.2) | 125(21.7) | 243(42.1) |
| 2 | Regardless of the patients age, disabilities, and patients personal preference, a person should be kept alive as long as possible\* | 261(45.2) | 64(11.1) | 66(11.4) | 99(17.2) | 87(15.1) |
| 3 | Patients with terminal illness should be allowed to die without making heroic efforts to prolong their lives | 117(20.3) | 90(15.6) | 114(19.8) | 107(18.5) | 149(25.8) |
| 4 | Withdrawal of life sustaining treatment in the case of passive euthanasia is the same as murder\* | 235(40.7) | 48(8.3) | 53(9.2) | 154(26.7) | 87(15.1) |
| 5 | Doctors have greater authority than patients in decisions about withholding life sustaining treatments | 155(26.9) | 76(13.2) | 47(8.1) | 167(28.9) | 132(22.9) |
| 6 | Physicians should comply with a patient’s/ family request to withhold or withdraw life-sustaining treatment | 121(21.0) | 34(5.9) | 22(3.8) | 185(32.1) | 215(37.3) |
| 7 | If necessary, a terminally ill patient should receive drugs to relieve pain and suffering, even if these drugs may hasten the end of the patient’s life | 73(12.7) | 22(3.8) | 68(11.8) | 240(41.6) | 174(30.2) |
| 8 | The place of dying (eg.home, hospital etc) in case of a terminally ill patient can be decided by the patient or patient party | 58(10.1) | 22(3.8) | 4(0.7) | 250(43.3) | 243(42.1) |
| 9 | It is cruel to prolong intense suffering for a person who is mortally ill and desires to die | 117(20.3) | 19(3.3) | 103(17.9) | 177(30.7) | 161(27.9) |
| 10 | There should be strict legislation regulating passive euthanasia procedures | 89(15.4) | 25(4.3) | 11(1.9) | 211(36.6) | 241(41.8) |
| 11 | Legalisation of passive euthanasia may lead to less aggressive treatment even to patients who can be cured of the disease/suffering | 181(31.4) | 111(19.2) | 124(21.5) | 85(14.7) | 76(13.2) |
| 12 | If a terminally ill patient wishes to die, the wish can be honoured ethically | 144(25.0) | 27(4.7) | 47(8.1) | 88(15.3) | 271(47.0) |
| 13 | If a terminally ill patient wishes to die, the wish can be honoured legally | 142(24.6) | 79(13.7) | 8(1.4) | 159(27.6) | 189(32.8) |

\*negatively keyed items

**Table 3: In the case of withholding and withdrawing life support while doing passive euthanasia for a terminally ill patient, how would you rate the following areas? (N=577)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| S.No | **Statement** | Strongly disagree  n(%) | Disagree  n(%) | Not sure  n(%) | Agree  n(%) | Strongly agree  n(%) |
| 1 | Declaration (consent) from patient/ family members must be obtained before the act of Passive euthanasia. | 0 | 0 | 34(5.9) | 179(31.0) | 364(63.1) |
| 2 | Families should be informed about the advantages and limitations of further therapy and further prognosis | 0 | 0 | 24(4.2) | 224(38.8) | 329(57.0) |
| 3 | Withholding and withdrawing treatment in case of passive euthanasia are ethically the same | 30(5.2) | 23(4.0) | 86(14.9) | 149(25.8) | 289(50.1) |
| 4 | Withholding or withdrawing life support while doing passive euthanasia is unethical. | 236(40.9) | 86(14.9) | 108(18.7) | 72(12.5) | 75(13.0) |
| 5 | Withholding is more ethical than withdrawing | 34(5.9) | 11(1.9) | 320(55.5) | 169(29.3) | 43(7.5) |
| 6 | Withdrawing is more ethical than withholding | 114(19.8) | 27(4.7) | 201(34.8) | 182(31.5) | 53(9.2) |

**Table 4: How important are the following factors in influencing your decision making regarding passive euthanasia to a terminally ill patient? (N=577)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| S.No | **Patient factors** | Not important  n(%) | Less important  n(%) | Neutral  n(%) | Important  n(%) | Very important  n(%) |
| 1 | Age of the patient | 68(11.8) | 16(2.8) | 124(21.5) | 155(26.9) | 214(37.1) |
| 2 | Quality of life as viewed by the patient | 81(14.0) | 19(3.3) | 25(4.3) | 317(54.9) | 135(23.4) |
| 3 | Quality of life as viewed by the family | 60(10.4) | 14(2.4) | 174(30.2) | 156(27.0) | 173(30.0) |
| 4 | Patient unlikely to survive and there are not much alternative treatments. | 63(10.9) | 15(2.6) | 96(16.6) | 217(37.6) | 186(32.2) |
| 5 | At patient/family members request | 63(11.1) | 14(2.4) | 75(13.0) | 131(22.7) | 293(50.8) |
| 6 | Financial costs to patient/family | 95(16.5) | 22(3.8) | 76(13.2) | 205(35.5) | 179(31.0) |
| **Doctor related factors** | | | | | | |
| 7 | Personal values and attitude | 143(24.8) | 25(4.3) | 137(23.7) | 97(16.8) | 175(30.3) |
| 8 | Humanitarian basis | 76(13.2) | 11(1.9) | 118(20.5) | 156(27.0) | 216(37.4) |
| 9 | Religious belief | 175(30.3) | 28(4.9) | 126(21.8) | 109(18.9) | 139(24.1) |
| 10 | knowledge acquired from medical education | 134(23.2) | 23(4.0) | 92(15.9) | 134(23.2) | 194(33.6) |
| 11 | ICU bed availability | 110(19.1) | 18(3.1) | 93(16.1) | 180(31.2) | 176(30.5) |
| 12 | Litigation or breaking the law | 81(14.0) | 13(2.3) | 207(35.9) | 166(28.8) | 110(19.1) |

**Table 5: Association between selected variables and attitude regarding Passive Euthanasia (N=560)\***

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **Attitude regarding Passive Euthanasia** | | **P value** |
| **Negative**  **n(%)** | **Positive**  **n(%)** |
| **Sex** | | | |
| Male | 64 (16.0) | 316 (83.2) | 0.67 |
| Female | 33 (18.3) | 147 (81.7) |
| **Age group** | | | |
| 24-40 | 65 (16.4) | 332 (83.6) | 0.36 |
| >40- 63 | 32 (19.6) | 131 (80.4) |
| **Marital status** | | | |
| Single | 37 (16.8) | 183 (83.2) | 0.80 |
| Married | 60 (17.6) | 280 (82.4) |
| **Religion** | | | |
| Hindu | 79 (17.6) | 371 (82.4) | 0.62 |
| Others | 16 (15.5) | 87 (84.5) |
| **Working category** | | | |
| PGT | 57(16.0) | 300(84.0) | 0.26 |
| Faculties | 40 (19.7) | 163 (80.3) |
| **Specialisation** | | | |
| Clinical | 72 (17.4) | 342 (82.6) | 0.94 |
| Non- clinical | 25 (17.1) | 121 (82.9) |
| **ICU experience** | | | |
| Yes | 14 (13.7) | 88 (86.3) | 0.28 |
| No | 83 (18.2) | 374 (81.8) |

\*respondents with neutral attitude were excluded from analysis