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Dialogue rather than debate on assisted dying

INVITERT KOMMENTAR

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Important discussions are taking place about life-prolonging treatment, fair priority setting and assisted dying. Challenges arise when these topics are conflated, terms are used as if they are interchangeable, there is a lack of empirical data and arguments from one discourse are used to influence another.

Doctors' opinions on assisted dying influence both public debate and what can be implemented in practice. Magelssen et al. have studied Norwegian doctors' attitudes to assisted dying based on data from a survey conducted in 2024 (1). A similar survey was conducted in 2016 (2), and international studies on doctors' attitudes are published regularly. Societal changes and contextual factors underscore the need for up-to-date local data.

Quantitative studies of self-reported attitudes require rigorous analysis and careful interpretation. What data are being highlighted and discussed? The Norwegian study shows that doctors are still opposed to assisted dying, particularly in relation to patients with a long life expectancy or a mental illness (1). In 2016, 48 % of doctors strongly disagreed with the legalisation of physician-assisted suicide for terminally ill patients with a short life expectancy (Statement 1), compared to 36 % in 2024, which is a significant decrease. The proportion who strongly agreed rose from 9 % to 12 %. These figures show that the majority remain sceptical, but as the authors themselves point out, the picture becomes more nuanced when including those with more moderate responses: 39 % and 50 % express some level of agreement or disagreement, respectively. Someone advocating for a less restrictive approach might highlight that 39 % of doctors support assisted dying, while critics might present it as only 12 % in favour. Statistical data can thus be used and presented strategically in debates, and isolated findings can be used to support different viewpoints. Additionally, a sampling bias with respect to sex and age suggests that support for legalisation may be somewhat underestimated. This narrows the gap with Swedish doctors, 47 % of whom supported legalisation of physician-assisted suicide (3).

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A notable increase from the 2016 to the 2024 survey is observed in the categories 'agree', 'neither agree nor disagree', and 'disagree' for Statement 1. The authors interpret the middle category responses as a reflection of some respondents not having a firm opinion and being 'uncertain and more easily influenced by public debate, arguments or the specific content of any proposed law'. An alternative interpretation is that reflecting on complex ethical issues leads to more nuanced and less definitive responses (4). Perhaps there is now a greater degree of ethical reflection among doctors, potentially as a result of increased attention in medical education, the media and public discourse? In addition, doctors are encountering an increasing number of patients who want to exercise self-determination and their rights. Maybe more doctors are acknowledging valid ethical arguments on both sides and therefore refraining from taking a definitive stance? Or have personal experiences in clinical practice revealed that the boundaries are sometimes blurred?

During meetings with staff at Bergen Hospital Trust's Clinical Ethics Committee, we have seen how a fear of assisted dying can complicate discussions about withdrawing life-prolonging treatment. In several cases, the withdrawal of treatment for seriously ill patients has wrongly been referred to as euthanasia, while continuing treatment has been described by some as torture. These examples underscore the importance of using precise language and knowledge dissemination, particularly within the medical community. Withdrawing life-prolonging treatment when no benefit is expected is good medical practice, not assisted dying. There is also a need to revise relevant guidelines, raise awareness of them and improve implementation – for example, regarding palliative sedation (5).

Similarly, discussions about resource prioritisation can be derailed by fears that a shortage of resources might lead to patients seeking assisted dying. However, prioritisation is about the fair and efficient distribution of healthcare resources. We must work together to ensure that resources are allocated in line with our shared values, and that patients and their families can trust they will receive appropriate care and treatment when seriously ill and approaching the end of life. We need open, explicit discussions about prioritisation and non-treatment decisions without uncritically conflating them with the assisted dying debate.

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We also need an open dialogue rather than a polarised debate on assisted dying. Dialogue entails exploring and understanding each other's perspectives, while debate is about persuading our opponents or winning an argument. A national review of assisted dying has been called for to ensure transparency, broad participation and a process that builds trust (6, 7). When presenting the White Paper on Priority Setting, the Minister of Health and Care Services, Jan Christian Vestre, stated that resource prioritisation raises fundamental questions concerning core societal values and should therefore not be politicised as part of an election campaign; what it requires is collaborative efforts to find solutions (8). If the topic of assisted dying is raised in this year's election campaign, is it too much to hope for dialogue rather than debate?

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