Original article **Svein Aarseth, Morten Horn, Morten Magelssen, Magne Supphellen**

Norwegians' attitudes towards legalising assisted dying

Michael 2023; 20: 23–33. (English version)

Background: Knowledge of the population's attitudes towards assisted dying (euthanasia and physician-assisted suicide) is important to enable an informed discussion about a difficult topic.

Material and method: An online survey of a representative sample of adults in Norway. The respondents were asked to take a position on five statements about the legalisation of assisted dying, defined as an umbrella term that covers euthanasia and physician-assisted suicide, in different situations. The responses were analysed using descriptive statistics and logistic regression.

Results: A total of 1167 people completed the survey (response rate 23.7%). The degree of support for the legalisation of assisted dying varies depending on the patient situation in question. Support is strongest for physician-assisted suicide in terminally ill patients with a short remaining life expectancy. Here, 34% strongly agreed and 34% agreed to some extent with legalisation, while 10% and 9% strongly disagreed or disagreed to some extent, respectively. The 30–44 age group was most in favour of legalisation.

Interpretation: Support for assisted dying depends on the indication. In most situations, more than half are undecided. There is less support for assisted dying in cases of mental disorders and 'completed lives'. The population is more in favour of the legalisation of assisted dying than doctors.

Opinion polls indicate a persistently high level of support for assisted dying among the population in Norway, as in other Western countries. In a survey from 2015, 38% 'Strongly agreed' and 36% 'Agreed to some extent' that physician-assisted suicide should be permitted for terminally ill patients with a short remaining life expectancy (1). In opinion polls reported by the media, between 60% and 80% of respondents normally show support for the legalisation of assisted dying. For example, in a public opinion survey conducted

in Norway in 2019, three out of four respondents were in favour of assisted dying (2). This is roughly the same as in other Scandinavian countries (3). An international literature review from 2016 found that support for legalisation was high, and growing, in Western Europe, while in the United States it has been consistently high (4). Comparisons between studies are often difficult because of the differences in definitions and the wording of questions.

A study of doctors' attitudes from 2016 found that 9% and 21% 'Strongly agreed' or 'Agreed to some extent', respectively, with the legalisation of physician-assisted suicide (5). In a recent, smaller study, it was found that 56% of nurses supported such legalisation (6).

Several countries allow assisted dying in the form of euthanasia, physician-assisted suicide or both (7). In Norway, most political parties are against legalising assisted dying. Public opinion surveys can influence politicians' views on the subject.

In this article, we present results from a recent nationally representative survey carried out in Norway in the autumn of 2021. In addition to updating our understanding of public opinion, we wanted to gain new insight into how attitudes towards legalisation are affected by the clinical picture that respondents are envisioning when describing their attitude (terminal illness, chronic illness, mental illness, etc.).

Material and method

The survey was initiated and financed by the Medical Ethics Council. This was reflected in the questionnaire. The questionnaire was developed by the authors based on questions asked previously and on input from research colleagues (1, 8). In the introduction, *assisted dying* was defined as an umbrella term for *euthanasia* and *physician-assisted suicide* (3, 9). Euthanasia was defined as 'a doctor intentionally bringing about a person's death by injecting lethal drugs at the person's request' (9). Physician-assisted suicide was defined as follows: 'a doctor provides lethal drugs that the person self-administers'. Although the wording has been slightly adjusted, the definitions are in line with those used in the studies of the population's and doctors' attitudes in 2015–16 (1, 5).

The respondents were asked to take a position on five statements about the legalisation of assisted dying. The response alternatives were 'Strongly disagree', 'Disagree to some extent', 'Neither agree nor disagree', 'Agree to some extent', 'Strongly agree' and 'Don't know'. The five statements had almost exactly the same wording as in the two previous surveys, making the results comparable.

The survey was conducted by Kantar, a data analysis company. Kantar's Gallup panel consists of approximately 40,000 people and strives to be representative of the adult population. An invitation was emailed to members of the panel with a request to answer an online questionnaire. Responding to the survey was considered implicit consent to participate. The data protection officer at the Norwegian Centre for Research Data (NSD, ref. 629574) considered the survey to be in accordance with data protection legislation.

In panel surveys, a higher weighting is normally given to the answers of respondents who belong to groups that are underrepresented in the sample. In line with this, the answers are weighted with regard to age, gender and region of residence (Table 1). The data were analysed using SPSS 27 and presented using descriptive statistics and logistic regression. In the latter, the answers of those who indicated 'Agree to some extent' and 'Strongly agree' were combined, as were the answers 'Christian' (33.5%) and 'Other religious worldview (2.3 %).

Results

The questionnaire was sent to 4929 people, 1167 of whom completed the survey (response rate 23.7%). The demographics of respondents are shown in Table 1.

Table 2 gives a breakdown of responses to the five statements about assisted dying. The strongest support for the legalisation of physician-assisted suicide was seen for terminally ill patients with a short remaining life expectancy. Here, 34% strongly agreed and 34% agreed to some extent with legalisation. Euthanasia in the same situation had somewhat less support. On the question of legalising assisted dying for chronically ill patients, the responses were fairly evenly distributed between the different alternatives. Only a few supported assisted dying for mental illness alone (3% strongly agreed, 9% agreed to some extent) or tiredness of life without serious illness (4% and 10%).

Logistic regression analysis showed that respondents who were religious were less likely to support legalisation (Table 3). There were no significant gender differences.

Attitudes towards assisted dying varied between age groups, but with age as a continuous variable there was no/minimal effect (odds ratio 0.99–1.00 for the three statements analysed in Table 3). Differences were found across each of the four age groups < 30 years, 30–44 years, 45–59 years, and 60 years and over: the 30–44 age group was consistently most in favour of legalisation, while the oldest group (60 years and over) were least in favour of legalisation. The youngest group (< 30 years) was more in favour than

the oldest group of the legalisation of euthanasia in cases of a short remaining life expectancy. The 45–59 age group was more in favour than the oldest group of the legalisation of physician-assisted suicide in cases of a short remaining life expectancy, but otherwise did not differ from the oldest group (60 years and over).

The attitudes towards physician-assisted suicide and euthanasia respectively in cases of a short remaining life expectancy had a correlation coefficient of 0.62 ($p < 0.001$).

Discussion

One-third of the respondents were strongly in favour of the legalisation of assisted dying, one-tenth were strongly against it, and the rest were somewhere in between. Fewer were in favour of legalisation in cases of chronic life-threatening illness, and very few supported assisted dying in cases of mental illness and life fatigue.

Strengths and weaknesses

One of the weaknesses of the study is the low response rate. This means that response bias cannot be ruled out. Low response rates are a problem

		Unweighted (N (%))	Weighted (N (%))
Age	Below 30 years	128 (11.0)	230 (19.7)
	30–44 years	330 (28.3)	299 (25.6)
	45–59 years	320 (27.4)	299 (25.6)
	60 years and over	389 (33.3)	340 (29.1)
Gender	Female	610 (52.3)	579 (49.6)
	Male	557 (47.7)	588 (50.4)
Education	Primary/lower secondary school	48 (4.1)	44 (3.8)
	Upper secondary school	268 (23.0)	283 (24.2)
	Vocational college	107 (9.2)	115 (9.8)
	University/university college <5 years	401 (34.4)	398 (34.1)
	University/university college ≥5 years	343 (29.4)	328 (28.1)
Region of residence	Oslo and area	304 (26.0)	296 (25.3)
	Remainder of Eastern Norway	295 (25.3)	300 (25.7)
	Southern and Western Norway	353 (30.2)	361 (30.9)
	Trøndelag/Northern Norway	212 (18.2)	208 (17.8)

Table 1. Demographics of the respondents.

	Strongly disagree	Disagree to some extent	Neither agree nor disagree	Agree to some extent	Strongly agree	Did not answer	Total
Physician-assisted suicide (a doctor provides lethal drugs that the person self-administers) should be permitted in terminally ill patients with a short remaining life expectancy	119 (10.2)	104 (8.9)	148 (12.7)	396 (33.9)	396 (33.9)	4 (0.3)	1167 (100)
Euthanasia (a doctor injects lethal drugs) should be permitted in terminally ill patients with a short remaining life expectancy	159 (13.7)	146 (12.5)	174 (14.9)	375 (32.1)	310 (26.5)	3 (0.3)	1167 (100)
Assisted dying (i.e. both physician-assisted suicide and euthanasia) should be permitted in patients with an incurable chronic illness, but not terminally ill	237 (20.3)	218 (18.7)	255 (21.9)	307 (26.3)	146 (12.5)	4 (0.3)	1167 (100)
Assisted dying should be permitted in the case of mental illness alone	530 (45.4)	274 (23.5)	219 (18.8)	101 (8.6)	38 (3.3)	5 (0.4)	1167 (100)
Assisted dying should be permitted for people with tiredness of life who want to die but have no serious illness	586 (50.2)	232 (19.9)	177 (15.2)	122 (10.5)	46 (4.0)	4 (0.4)	1167 (100)

Table 2 Attitudes towards the legalisation of assisted dying. Number and (percentage).

in many surveys (10), but analyses indicate that the responses may still be representative (11). The sample was drawn from a panel that is representative of the population, and the answers were weighted based on demographic parameters.

Comparisons with other studies

In 2019, two public opinion surveys were conducted on attitudes towards assisted dying. In one survey, 51% were in favour (12), and in an opinion poll, 77% were in favour of legalising 'active euthanasia' in Norway (2). The surveys consisted of a single question about legalisation and 'Yes', 'No',

	Physician-assisted suicide with short remaining life expectancy		Euthanasia with short remaining life expectancy		Assisted dying for chronic illness	
	Bivariate	Multivariate	Bivariate	Multivariate	Bivariate	Multivariate
Gender (Female)	1.11 (0.86–1.42)	1.27 (0.97–1.65)	0.81 (0.64–1.02)	0.91 (0.71–1.16)	0.93 (0.73–1.17)	0.99 (0.78–1.27)
Age < 30		0.93 (0.64–1.35)		1.51 (1.06–2.16)*		1.26 (0.88–1.80)
30–44		1.83 (1.27–2.65)**		1.89 (1.35–2.65)***		1.72 (1.24–2.39)**
45–59		1.44 (1.02–2.05)*		1.04 (0.75–1.43)		0.85 (0.61–1.20)
Religiosity	0.35 (0.27–0.45)***	0.34 (0.26–0.44)***	0.48 (0.37–0.61)***	0.52 (0.40–0.67)***	0.60 (0.47–0.78)***	0.65 (0.50–0.85)**

*: p<0,05; **: p<0,01; ***: p<0,001.

Table 3. The importance of gender, age and religiosity for whether the respondents agreed strongly or to some extent with the legalisation of assisted dying. Bivariate and multivariate regression analyses. For age, > 60 years was the reference category. Odds ratio (95% confidence interval).

'Don't know' response alternatives. Our survey allowed respondents to nuance and qualify their views. They could do this in two ways: by nuancing their support for or opposition to legalisation with the response alternatives 'Agree to some extent' and 'Disagree to some extent', and by making a distinction between the different situations, and qualifying their support for legalisation as applying to some situations but not others.

In this survey, we have closely followed the questions and definitions from a survey conducted in 2015 (1), but use the term 'assisted dying' instead of 'active euthanasia'. The same questions were used in a survey of doctors' attitudes from 2016 (5). As with the survey from 2015, our survey shows that there is support for assisted dying, particularly in terminally ill patients with a short remaining life expectancy. As before, there is less support for the legalisation of assisted dying in other situations.

The population is much more in favour of the legalisation of assisted dying than doctors (Table 4). Possible explanations could be the medical profession's traditional opposition to assisted dying, and doctors' experiences with the end-of-life phase and knowledge that it is often possible to provide good palliative care.

The population's support for legalisation seems to have decreased somewhat, or at least not increased, since 2015. However, since both surveys had a low response rate, differences must be interpreted with caution.

In international studies, younger, highly educated, male and non-religious respondents tend to be more supportive of the legalisation of assisted dying (13). In our study, those who were non-religious were more often in favour of legalisation, and no gender difference was found (Table 3). The age group 30–44 years was most in favour of legalisation, and more in favour than the youngest group (< 30 years), which was a surprising finding.

Implications of the findings

The nuances in the response alternatives allow for different interpretations of the results. A widely used interpretation would be to combine those who strongly agree and agree to some extent into a single group of 'Agree', and to combine those who strongly disagree and disagree to some extent into a single group of 'Disagree'. This would mean that 68% of respondents are in favour of physician-assisted suicide in terminally ill patients with a short remaining short life expectancy. The corresponding figure for euthanasia is 59%.

However, there is also another way to interpret the answers: only those who 'Strongly agree' and 'Strongly disagree' can be considered as absolutely in favour of or opposed to legalisation, respectively. The respondents in the three categories in the middle – 'Disagree to some extent', 'Neither agree nor disagree' and 'Agree to some extent' – could be viewed as not being fully decided on the matter. In this interpretation, the respondents are divided into

	Physician-assisted suicide for terminal illness		Euthanasia for terminal illness		Assisted dying for chronic illness		Assisted dying for life fatigue	
Studie	**Strongly agree**	**Agree to some extent**	**Strongly agree**	**Agree to some extent**	**Strongly agree**	**Agree to some extent**	**Strongly agree**	**Agree to some extent**
This study	34	34	27	32	13	26	4	10
Magelssen et al. 2016 (8) (survey of the public)	38	36	34	33	15	23	6	12
Gaasø et al. 2019 (5) (survey of doctors)	9	22	8	17	4	9		

Table 4. Comparison of three surveys of attitudes towards the legalisation of assisted dying. The proportion who answered 'Strongly agree' and 'Agree to some extent' is shown for four key statements (%).

three: those who are strongly in favour of legislation, those who are strongly against legalisation, and the large group in the middle. Our figures show that the size of this group in the middle varies depending on the specifics of the question, according to what type of assisted dying is being asked about, and what patients it would apply to. This undecided group constitutes between 56% and 67% in the first three questions in the survey (Table 2).

Perhaps this three-way split of respondents into *strongly in favour of*, *strongly against*, and *neither strongly for nor against*, gives just as accurate a picture as the traditional dichotomy of for/against. The three-way split certainly provides better insight into what steers the population's attitudes towards assisted dying, and what conditions a potential law on assisted dying would have to meet in order to gain support from a majority of the population.

A third of the population is strongly in favour of assisted dying, and is unlikely to be influenced by public discourse or by details in a parliamentary bill. It is conceivable that this category includes people who have had intensely negative experiences as the family of someone who had a difficult death, or people who have a principled position deeply rooted in human rights. A small group, 10%, is strongly against assisted dying, and are unlikely to be swayed into changing their minds. This category includes people whose opposition is rooted in a deeply religious conviction (13), as well as many doctors (5). The final position decided by the large group in the middle could have an impact on potential legislation in the area. We assume that this group includes people who see arguments for and arguments against the legalisation of assisted dying. They are likely to have certain requirements for the design of a potential law on assisted dying, whom it should apply to, and how it should be enforced. This is reflected in the responses to the statements on attitudes towards assisted dying in different situations.

The type of assisted dying matters to the respondents. This is most strongly expressed in response to the statements about assisted dying for patients with mental illness alone, or patients with tiredness of life but no serious illness. Here, 45–50% strongly disagree, while only 3–4% strongly agree that assisted dying should be legalised in these situations. It is therefore mainly in cases of terminal illness with a short remaining life expectancy that Norwegians support the possibility of assisted dying, not in other situations. In light of this, it is interesting to note that existing laws on assisted dying in some countries, such as the Netherlands, allow assisted dying in the case of mental illness alone (14). There is also an ongoing debate in the Netherlands about whether assisted dying should be allowed for older people who have lived what is referred to as a 'completed life' (15). In Canada, which introduced assisted dying in 2016, there is now a debate on whether

mental illness alone should qualify people for assisted dying (16). It cannot be assumed that assisted dying, if it is legalised, will be limited to people with a somatic disorder with a fatal outcome and a short life expectancy.

Conclusion

The population expresses support for the legalisation of assisted dying in some situations, most strongly in the case of physician-assisted suicide in terminally ill patients with a short remaining life expectancy. However, only a minority take the extreme positions of 'Strongly agree' or 'Strongly disagree'. A large proportion of respondents belong to the more undecided group in the middle. The population is more in favour of the legalisation of assisted dying than doctors. The support is heavily dependent on how assisted dying might be delineated. The population's support for legalisation seems to have decreased somewhat, or at least not increased, since 2015. However, since both surveys had a low response rate, differences must be interpreted with caution.

References

1. Magelssen M, Supphellen M, Nortvedt P et al. Attitudes towards assisted dying are influenced by question wording and order: a survey experiment. *BMC Med Ethics* 2016; 17: 24. https://doi.org/10.1186/s12910-016-0107-3
2. Andersen JE, Skogrand M. Tre av fire sier ja til aktiv dødshjelp. *Dagbladet* 1.3.2019; Tre av fire sier ja til aktiv dødshjelp (dagbladet.no) (16.10.2022).
3. Kleiven DJH, Hartling O, Ståhle F et al. Dødshjelp: Lovverk, praksis og holdninger i de skandinaviske land. I: Horn MA, Kleiven DJH, Magelssen M, red. *Dødshjelp i Norden? Etikk, Klinikk og politikk*. Oslo: Cappelen Damm, 2020: 51–73. https://doi.org/10.23865/noasp.96.ch3
4. Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW et al. Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe. *JAMA* 2016; 316: 79–90. https://doi.org/10.1001/jama.2016.8499
5. Gaasø OM, Rø KI, Bringedal B et al. Legers holdning til aktiv dødshjelp. *Tidsskr Nor Legeforen* 2019; 139. https://doi.org/10.4045/tidsskr.18.0391
6. Hol H, Vatne S, Orøy A et al. Norwegian nurses' attitudes toward assisted dying: a cross-sectional study. *Nursing: Research and Reviews* 2022; 12: 101–9. https://doi.org/10.2147/NRR.S363670
7. Euthanasia & Physician-Assisted Suicide (PAS) around the World: https://euthanasia.procon.org/euthanasia-physician-assisted-suicide-pas-around-the-world/ (16.10.2022).
8. NOBAS – Norwegian Bioethics Attitude Survey. Rapport 2015: http://bioetikk.no/wp-content/uploads/2018/05/NOBAS-rapport-2015.pdf (16.10.2022).
9. Magelssen M. Språk og virkelighet i dødshjelpsdebatten. I: Horn M, Kleiven DJH, Magelssen M, red. *Dødshjelp i Norden? Etikk, klinikk og politikk.* Oslo: Cappelen Damm Akademisk, 2021: 35–49. https://doi.org/10.23865/noasp.96.ch2

10. Groves RM. Nonresponse rates and nonresponse bias in household surveys. *Public Opin* 2006; 70: 646–75. https://doi.org/10.1093/poq/nfl033
11. Hellevik O. Extreme nonresponse and response bias. *Quality & Quantity* 2016; 50: 1969–91. https://doi.org/10.1007/s11135-015-0246-5
12. Giæver O, Knipperud T. 51 prosent sier ja til aktiv dødshjelp. ABC Nyheter. Oslo: Ny undersøkelse: 51 prosent sier ja til aktiv dødshjelp | ABC Nyheter (16.10.2022).
13. Sabriseilabi S, Williams J. Dimensions of religion and attitudes toward euthanasia. *Death Stud* 2022; 46: 1149–56. https://doi.org/10.1080/07481187.2020.1800863
14. Román S. Psykiatri och dödshjälp. I: Horn M, Kleiven DJH, Magelssen M, red. *Dødshjelp i Norden? Etikk, klinikk og politikk.* Oslo: Cappelen Damm Akademisk, 2021: 213–33. https://doi.org/10.23865/noasp.96.ch11
15. Holm S. Er det at blive gammel tilstrækkelig årsag til dødshjælp? I: Horn M, Kleiven DJH, Magelssen M, red. *Dødshjelp i Norden? Etikk, klinikk og politikk*. Oslo: Cappelen Damm Akademisk, 2021: 235–48. https://doi.org/10.23865/noasp.96.ch12
16. Third annual report on Medical Assistance in Dying in Canada 2021. Toronto: Government of Canada, 2022. Third annual report on Medical Assistance in Dying in Canada 2021 - Canada.ca (11.11.2022).

Svein Aarseth
svein.aarseth@legeforeningen.no
Medical Ethics Council
Norwegian Medical Association
PO Box 1152 Sentrum
NO-0107 Oslo

Svein Aarseth is a specialist in general practice and occupational medicine, and chair of the Medical Ethics Council.

Morten Andreas Horn
hormor@ous-hf.no
Department of Neurology
Oslo University Hospital
PO Box 4950 Nydalen
NO-0424 Oslo

Morten Andreas Horn, PhD, is a specialist in neurology and senior consultant at Oslo University Hospital. Member of the Medical Ethics Council 2018–21.

Morten Magelssen
morten.magelssen@medisin.uio.no
Centre for Medical Ethics
Institute of Health and Society
University of Oslo
PO Box 1130 Blindern
NO-0318 Oslo
and
MF Norwegian School of Theology, Religion and Society
Oslo

Morten Magelssen, PhD, MD, associate professor at the Centre for Medical Ethics and professor II in bioethics at MF Norwegian School of Theology, Religion and Society.

Magne Supphellen
magne.supphellen@nhh.no
Norwegian School of Economics
Helleveien 30
NO-5045 Bergen

Magne Supphellen holds a Dr. Oecon degree, is a business economist, and a professor at the Norwegian School of Economics.

This article has been peer reviewed.