

# Latvian Population Attitudes Towards Euthanasia and Physician-Assisted Suicide: A Cross-Sectional Pilot Survey

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Euthanasia and physician-assisted suicide remain among the most contested issues in contemporary medical ethics. In Latvia, no form of euthanasia is currently legal, yet public debate periodically resurfaces, while empirical data on population attitudes are scarce. This cross-sectional pilot study evaluated knowledge, attitudes and personal experience related to euthanasia and assisted dying among Latvian residents. An anonymous online questionnaire (Google Forms) comprising demographic, knowledge, Likert-scale, scenario-based and open-ended items was distributed via convenience and snowball sampling. Of 485 respondents, 98.1% consented; the sample was predominantly female (85.2%), highly educated (76.1% with higher education) and aged 30-64 (77.5%). Awareness of euthanasia was high (97.3%), whereas only 46.6% felt adequately informed about palliative care. Support for legalization in the future reached 85.6%, and support was highest for passive euthanasia (84.5%) and oncology-related euthanasia (85.2%), lower for physician-assisted suicide (65.8%) and lowest for severe dementia (44.5%). Religious affiliation was the strongest differentiating factor: non-religious respondents supported legalization far more than Christians (94.2% vs 77.2%), whereas education, sex and region showed only modest differences. The most frequently required safeguards were unbearable persistent suffering (88.0%) and incurable disease (73.8%). Findings indicate strong public openness to regulated assisted dying alongside a pronounced palliative-care information gap. Results are exploratory given the non-representative sample.

*Keywords:* euthanasia, physician-assisted suicide, public attitudes, palliative care, end-of-life ethics, Latvia

## Introduction

Euthanasia and physician-assisted suicide (PAS) occupy a central and highly sensitive place in contemporary medical and bioethical discourse. Over the past three decades, several jurisdictions have moved from prohibition towards regulated legalization, and the international evidence based on the practice and acceptability of assisted dying has expanded considerably (Emanuel, Onwuteaka-Philipsen, Urwin, & Cohen, 2016). In Canada, Belgium and the Netherlands, oncological disease remains the most common underlying condition, although its relative share is gradually declining as requests linked to multimorbidity, neurodegenerative and—in Belgium and the Netherlands—psychiatric disorders increase (Health Canada, 2025; FCCEE, 2025; RTE, 2024).

In Latvia, no form of euthanasia is currently permitted by law; intentional ending of life falls under the

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Criminal Law, and patient autonomy at the end of life is framed by the Law on the Rights of Patients<sup>1</sup>. Despite the recurring nature of public debate, structured empirical data on the attitudes, knowledge and personal experience of the Latvian population are largely absent. International surveys have documented a steady rise in public acceptance of euthanasia across European countries (Cohen et al., 2006), but Latvia has rarely been included in such comparative work.

Understanding public attitudes is a prerequisite for any informed health-policy or bioethical discussion. The present study was conceived as a small but structured pilot survey designed to provide preliminary data on the knowledge, attitudes and experience of Latvian residents, and to identify demographic factors associated with differing positions.

### **The Aim of the Article**

The principal aim of this study was to assess the attitudes of the Latvian population towards the possible legalization of euthanasia and physician-assisted suicide. The specific objectives were: (1) to evaluate support for, or opposition to, different forms of euthanasia; (2) to analyze how demographic factors and personal experience are associated with these attitudes; (3) to identify the arguments and safeguards that respondents consider most important; and (4) to assess understanding of core concepts such as euthanasia and palliative care.

### **Material and Methods**

This was a cross-sectional quantitative pilot study. Data were collected by means of an anonymous online questionnaire administered through Google Forms over a period of approximately one to two months in early 2026. The questionnaire comprised 25 items grouped into six sections: demographic data; knowledge and experience; attitudinal statements rated on a five-point Likert scale (1 = strongly disagree, 5 = strongly agree); evaluation of clinical scenarios; policy and public-engagement views; and two open-ended questions on arguments for and against legalization. Average completion time was five to seven minutes.

Inclusion criteria were age 18 years or older, residence in Latvia, and voluntary informed consent. The recruitment strategy combined convenience and snowball sampling, with participants invited through social networks, e-mails and the authors' professional and personal contacts. No identifying data—including names, personal identity codes, e-mail or IP addresses—were collected.

Data were analyzed using descriptive statistics (frequencies and percentages) and simple subgroup comparisons by sex, age, education, religious affiliation and region of residence. Given the pilot nature of the study and the non-probability sample, a threshold of  $p < 0.05$  was regarded as relevant for exploratory purposes only. The study protocol and informed-consent form were prepared in accordance with the General Data Protection Regulation (GDPR) and submitted to the Research Ethics Committee of Rīga Stradiņš University. Participation was voluntary and could be discontinued at any point without consequences.

### **Results**

A total of 485 individuals responded to the questionnaire, of whom 98.1% consented to participate. The sample was strongly skewed by sex, with 85.2% women and 14.6% men. The largest age groups were 45-64 years (43.3%) and 30-44 years (34.2%), followed by 65+ (10.9%) and 18-29 (11.5%). Higher education

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<sup>1</sup> Krimināllikums (Criminal Law of the Republic of Latvia). Section 116; Chapter 13. Rīga: Latvijas Vēstnesis. Pacientu tiesību likums (Law on the Rights of Patients). (2009). Adopted 17 December, 2009. Rīga: Latvijas Vēstnesis.

predominated (76.1%), with 22.1% holding secondary and only a small proportion basic education. Regionally, Riga accounted for the largest share (40.4%), followed by Vidzeme (23.1%), Kurzeme (18.4%), Latgale (9.9%) and Zemgale (8.2%). In terms of religious affiliation, 45.8% identified as Christian, 43.7% as belonging to no religion, and the remainder as other or undisclosed. Latvian was the predominant family language (90.7%). Demographic characteristics are summarized in Table 1.

Table 1

*Demographic Characteristics of the Sample (N = 485)*

Characteristic	Category	%
Sex	Female	85.2
	Male	14.6
Age (years)	18-29	11.5
	30-44	34.2
	45-64	43.3
	65+	10.9
Education	Higher	76.1
	Secondary	22.1
Region	Riga	40.4
	Vidzeme	23.1
	Kurzeme	18.4
	Latgale	9.9
	Zemgale	8.2
Religion	Christian	45.8
	No religion	43.7

*Note.* Source: authors' survey data, 2026.

Self-reported knowledge was high: 97.3% knew what euthanasia is, 80.4% understood physician-assisted suicide, and 98.1% were aware that euthanasia is not legally permitted in Latvia. By contrast, only 46.6% felt they had sufficient information about palliative care, while 51.8% did not, revealing a marked information gap. Two-thirds of respondents (67%) reported personal experience of caring for a seriously ill or dying relative.

On the five attitudinal statements, agreement was strong with the propositions that a person should have the right to decide about the end of their own life (65.2% rating 5) and that euthanasia could reduce the suffering of patients with incurable illnesses (80.2% rating 5). Concern about potential abuse was more divided, while religious or spiritual considerations were rated as unimportant (score 1) by 45.6% of respondents (Figure 1).

Support varied substantially across clinical scenarios (Table 2, Figure 2). It was highest for euthanasia in incurable oncological disease with pronounced suffering (85.2%) and for passive euthanasia (84.5%), intermediate for physician-assisted suicide (65.8%), and lowest for euthanasia in severe dementia (44.5%, with 40.2% undecided). Support for considering legalization in the future reached 85.6%, with only 6.7% opposed and 7.6% undecided.

Among possible mandatory safeguards, persistent unbearable suffering was selected most frequently (88.0%), followed by incurable disease (73.8%), a decision by a council of physicians (54.2%), a repeated written request by the patient (45.6%) and a psychiatric assessment (43.9%). Nearly two-thirds of respondents (64.5%) indicated willingness to take part in public consultation on the topic.

Subgroup analysis identified religious affiliation as the strongest differentiating factor for support of legalization. Among respondents who consented and answered the question (n = 471), those belonging to no religion supported legalization at 94.2%, compared with 77.2% of Christians and 77.8% of those of other religions—a difference of roughly 17 percentage points (Table 3, Figure 3). Opposition (“No”) among Christians was almost double that of the full sample (12.6% vs 7.0%).

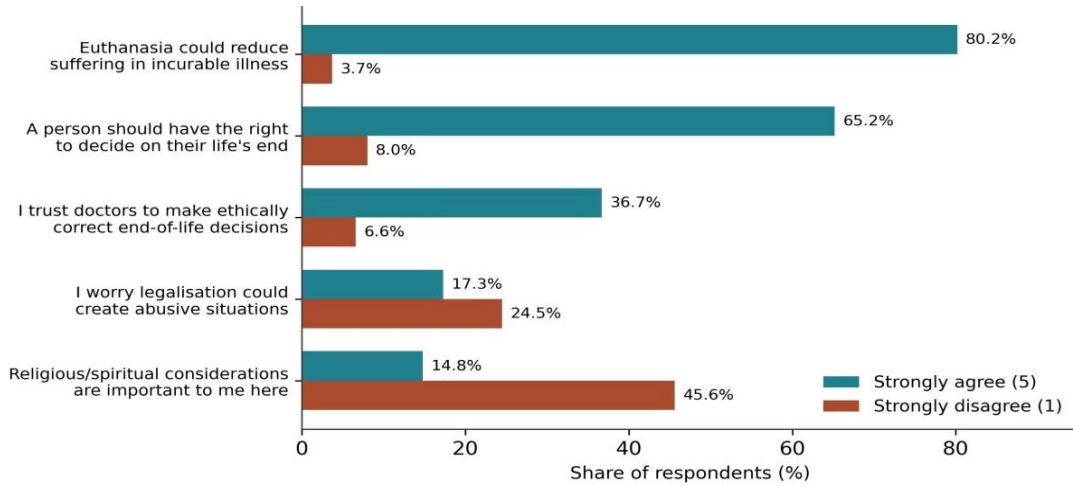


Figure 1. Attitudinal statements: share of respondents rating each statement 5 (strongly agree) and 1 (strongly disagree) on a five-point Likert scale (N = 485). Source: authors’ survey data, 2026.

Table 2

Support for Different Forms of Assisted Dying and for Future Legalization (N = 485)

Question	Yes (%)	No (%)	Hard to say (%)
Euthanasia in incurable oncological disease	85.2	5.1	9.7
Passive euthanasia (withdrawal of life support)	84.5	5.8	9.7
Physician-assisted suicide	65.8	12.4	21.9
Euthanasia in severe dementia	44.5	15.3	40.2
Future legalization should be considered	85.6	6.7	7.6

Note. Source: authors’ survey data, 2026.

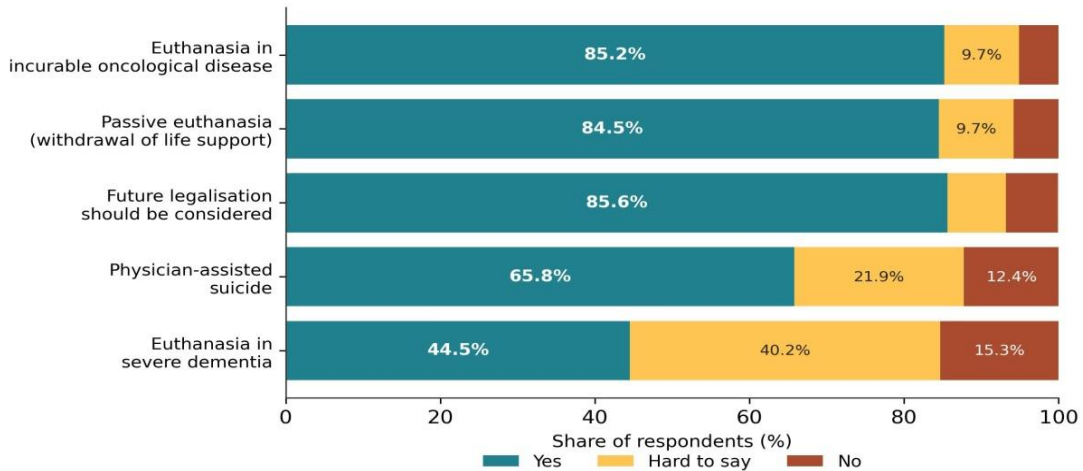


Figure 2. Support for different forms of assisted dying and for future legalization (N = 485). Source: authors’ survey data, 2026.

Table 3

*Support for Future Legalization by Religious Affiliation (N = 471)*

Religious affiliation	N	Yes (%)	No (%)	Hard to say (%)
Christianity	215	77.2	12.6	10.2
Other religion	18	77.8	11.1	11.1
Prefer not to say	32	87.5	3.1	9.4
No religion	206	94.2	1.5	4.4
Whole sample	471	85.4	7.0	7.6

*Note.* Source: authors' survey data, 2026. The "Other religion" group (n = 18) should be interpreted with caution because of the small subsample.

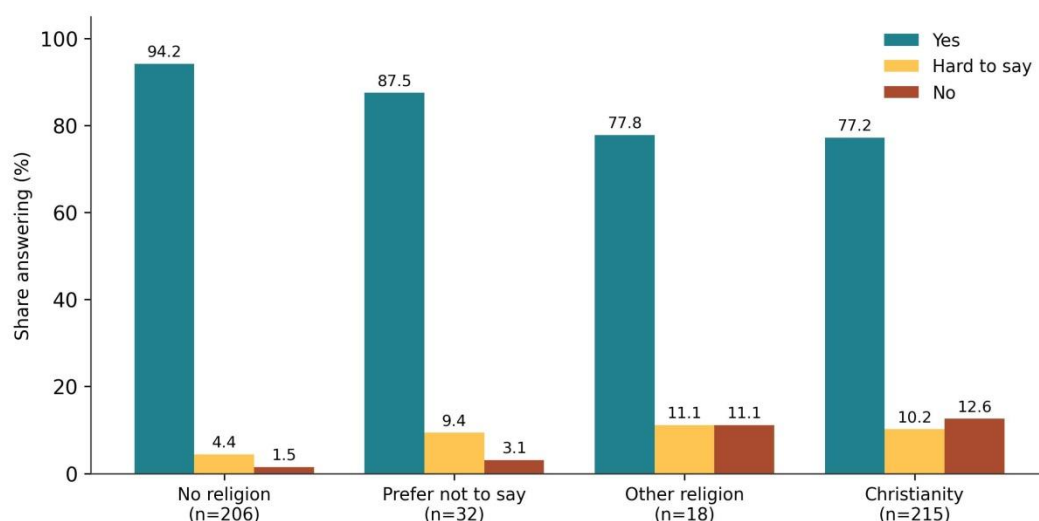


Figure 3. Support for future legalization of euthanasia by religious affiliation (n = 471).

Source: authors' survey data, 2026.

In contrast, education level showed no marked pattern: support was virtually identical among respondents with higher (85.2%) and secondary (86.5%) education. Differences by sex were also small in overall support (women 85.3%, men 87.0%), although men were more than twice as likely to answer "No" (13.0% vs 5.8%), while women were more often undecided. Regional differences were moderate: Vidzeme was consistently the most liberal region (89.5% support for legalization) and Latgale the most cautious (80.9%), a gap of 8.6 percentage points (Table 4). Smaller regional subsamples (Latgale n = 47; Kurzeme n = 39) warrant cautious interpretation.

Table 4

*Support for Selected Forms of Assisted Dying by Region (% Answering "Yes")*

Region	N	Oncology	Passive euth.	Phys.-assisted	Legalization
Riga	190	85.3	86.3	68.4	85.3
Zemgale	109	85.3	82.6	67.0	84.4
Vidzeme	86	87.2	88.4	65.1	89.5
Latgale	47	80.9	76.6	57.4	80.9
Kurzeme	39	84.6	82.1	61.5	84.6
Total	471	85.1	84.5	65.8	85.4

*Note.* Source: authors' survey data, 2026.

The open-ended responses (346 entries for arguments “for” and a comparable number “against”) were dominated, on the supporting side, by themes of relieving unbearable and untreatable suffering, respect for individual autonomy and dignity, and the perceived inadequacy of current palliative care. Several respondents recounted distressing personal experiences of relatives dying in pain. Arguments against legalization centered on the risk of abuse, religious and moral objections, the irreversibility of the act, distrust of the healthcare system, and the alternative of strengthening palliative care.

### **Discussion**

This pilot survey documents a high level of public openness towards regulated assisted dying in Latvia, with 85.6% of respondents supporting future consideration of legalization. This figure is broadly consistent with the upward trend in acceptance of euthanasia observed across European populations (Cohen et al., 2006) and aligns with the gradual normalization of assisted dying reflected in the registry data of Canada, Belgium and the Netherlands (Emanuel et al., 2016; Health Canada, 2025; RTE, 2024).

The strong gradient by religious affiliation—a 17-percentage-point gap between non-religious respondents and Christians—is in keeping with the international literature, in which religiosity is one of the most consistent predictors of opposition to euthanasia. The relatively flat profile across education, sex and region suggests that, within this sample, worldview rather than socio-economic position drives attitudes.

Equally notable is the contrast between very high support for passive euthanasia and oncology-related euthanasia and markedly lower, more hesitant support for euthanasia in severe dementia, where 40.2% were undecided. This pattern echoes international experience, where dementia and psychiatric conditions remain the most ethically contested indications and where advance directives raise particular difficulties (RTE, 2024). The high proportion selecting persistent unbearable suffering (88.0%) and incurable disease (73.8%) as mandatory conditions indicates that public support is conditional rather than unconditional, and is anchored in the relief of suffering rather than in autonomy alone—a finding that mirrors the consistently dominant role of loss of meaningful activity and dignity reported in the Canadian data (Health Canada, 2025).

A particularly relevant finding for clinical practice is the palliative-care information gap: only 46.6% of respondents felt adequately informed about palliative care, despite two-thirds having cared for a dying relative. This suggests that part of the demand for assisted dying may reflect unmet palliative-care needs and limited awareness of existing services, consistent with the position articulated by palliative-care bodies that high-quality palliative care and the assisted-dying debate must be considered together (Materstvedt et al., 2003).

Several limitations must be emphasized. The convenience and snowball sampling produced a sample that is not representative of the Latvian population: women, higher-education respondents and Riga residents were strongly over-represented, and the small male and regional subsamples limit statistical power. Self-selection is likely to have favored individuals already engaged with the topic, potentially inflating support. Reliance on self-reported knowledge and the absence of validated scales further constrain interpretation. The findings should therefore be regarded as exploratory and hypothesis-generating, providing a basis for a larger, representative study.

### **Conclusions**

Within the limits of a non-representative pilot sample, this study indicates that a large majority of participating Latvian residents are open to the future legalization of regulated assisted dying, with support

strongly conditioned on incurable disease and persistent unbearable suffering. Support is highest for passive and oncology-related euthanasia and considerably lower and more uncertain for severe dementia. Religious affiliation is the dominant differentiating factor, whereas education, sex and region play only minor roles. The pronounced palliative-care information gap suggests that strengthening palliative care and public education should accompany any policy discussion. These preliminary findings justify a larger, population-representative study to inform bioethical and health-policy debate in Latvia.

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