

2017

Ethical issues and attitudes towards euthanasia

Christa A. Mastro
Niagra University

Susan E. Mason
Niagra University

Follow this and additional works at: <https://scholar.utc.edu/mps>



Part of the [Psychology Commons](#)

Recommended Citation

Mastro, Christa A. and Mason, Susan E. (2017) "Ethical issues and attitudes towards euthanasia," *Modern Psychological Studies*: Vol. 22 : No. 2 , Article 5.

Available at: <https://scholar.utc.edu/mps/vol22/iss2/5>

This articles is brought to you for free and open access by the Journals, Magazines, and Newsletters at UTC Scholar. It has been accepted for inclusion in Modern Psychological Studies by an authorized editor of UTC Scholar. For more information, please contact scholar@utc.edu.

Ethical Issues and Attitudes towards Euthanasia

Christa A. Mastro and Susan E. Mason
Niagara University

Abstract

Case studies describing end-of-life scenarios were used to assess college students' attitudes toward euthanasia. Students used a five-point rating scale to judge if a case was ethical. Major field of study and religious conviction did not prove to be significant factors. The age of the person described in a scenario did influence ethics ratings, but not in the hypothesized direction. Euthanasia was judged to be more ethical in situations involving younger adults than in situations involving older adults.

Key words: euthanasia, ethics, healthcare, end-of-life care, case studies, aging

Cases concerning end-of-life procedures are difficult to judge against ethical standards because each case is unique. It is also true that decisions are influenced by the experiences, beliefs, and views of the individuals making the decisions. For example, physicians are expected to identify the most beneficial plan of care for the patient and to follow the patient's requests, as long as the patient is competent and of sound mind. However, the duty to protect patients' rights and independence may conflict with a physician's own morals. The doctor is obligated to discuss decisions with the patient, ensuring that treatment options are outlined and the patient's wishes are verbalized. Ultimately, though, the patient makes the final decision regarding the direction of medical treatment (Campbell, Gillet, & Jones, 2005).

The extent to which one accepts or rejects euthanasia as an option is likely to depend, in part, on one's religious beliefs (Aghababaei, Farahani, & Hatami, 2011; Newham, 2013). Some religious communities believe that if a person no longer considers life to be worthwhile and fulfilling then death is acceptable, while other religious groups condemn the taking of a life, declaring it to be immoral (Allen et al., 2006). One's religious beliefs may even influence professional decisions and behaviors (Caddell & Newton, 1995). In healthcare professions,

in particular, the morals of a care provider may impact the course of patient treatment (Gielen, van den Branden, & Broeckaert, 2009; Newham, 2013).

Caddell and Newton (1995) analyzed the degree to which organizational teachings, beliefs and attitudes in American society shape practitioners' actions and acceptance of euthanasia. Their research involved over 8,000 participants, ranging in age from 18 to 89 years. The sample included liberal, moderate, and conservative Protestants; Catholics; Jews; and individuals with no religious affiliation. Participants responded to questions regarding euthanasia, acceptance of euthanasia in terminal illness situations, religious affiliation, self-perception of religious beliefs, and educational status. Religiosity and education were found to correlate with views toward euthanasia. Persons viewing themselves as more liberal or with little or no religious affiliation were more accepting of euthanasia, and persons with graduate degrees were more accepting of active euthanasia and suicide.

Aghabaei et al. (2011), in their study of factors influencing attitudes toward euthanasia, also reported a relationship between religiosity and attitude. A sample of female student volunteers from the University of Tehran and Islamic Azad University, ranging in age from 19 to 43

years, completed either the Euthanasia Attitude Scale or the Attitudes Towards Euthanasia Scale, after completing the International Personality Item Pool, HEXACO Personality Inventory-Revised, and the Religious Orientation Scale-Revised. Attitude toward euthanasia was found to be related to both religiosity and conscientiousness - the stronger a person's religiosity or conscientiousness, the greater that person's negativity toward euthanasia.

A society's view of old age is another factor that may influence medical practices and attitudes toward euthanasia. In a retrospective study, Onwuteaka-Philipsen, Muller, and van der Wal (1997) collected data from reported cases of euthanasia in the Netherlands between the years 1984 and 1993. Information from police reports included interviews with physicians who performed euthanasia, patient files, and interviews or information provided by family members. With each case, the researchers determined the patient's age, gender, and illness; the physician specialization; and whether the death occurred by euthanasia, including physician-assisted suicide. For male patients, the average age at which euthanasia was performed was 62 years, with a range from 15 to 94 years. For female patients, the average age was 65, with a range from 17 to 95 years. The age decade in which euthanasia was most often performed was 60-69 for men and 70-79 for women. One explanation for the higher frequency of euthanasia performed in older adults is that older adults are more likely than younger adults to suffer from terminal illnesses. It is also possible that patient age is a factor influencing opinions about euthanasia, and that euthanasia is considered more acceptable when a patient is older.

We designed a study to further explore education, religiosity, and patient age as factors affecting attitudes toward euthanasia.

We hypothesized that euthanasia performed on older adults would be rated as more ethical than euthanasia performed with younger adult patients. We also hypothesized that, in comparison to individuals pursuing careers in other fields, those pursuing careers in health care would be more likely to reject euthanasia, regardless of the age of the patient. Finally, we predicted that participants would mention their religious beliefs frequently when explaining why they rated scenarios involving euthanasia as unethical.

Method

Our sample consisted of 97 college students, 16 men and 86 women, who ranged in age from 18 years to 27 years ($M = 19.68$, $SD = 1.60$). Participation was voluntary and there was no monetary compensation.

We developed a questionnaire with six end-of-life case-study scenarios (see Appendix), three depicting young adults (in their 20's or 30's) and three depicting old adults (in their 70's or 80's). The young adults included a 26-year old man with leukemia, a 38-year old woman with brain damage, and a 28-year-old woman with multiple sclerosis. The old adults included a 75-year-old man with emphysema, congestive heart failure, and colon cancer; a 77-year-old woman with dementia; and an 88-year-old man with pneumonia and lung cancer. The presentation order alternated between young and old. Following each case study, participants were asked to rate how ethical the situation was, using a scale of 1 (least ethical) to 5 (most ethical), and then provide an explanation for the rating. After evaluating the six case studies, participants were asked to report their age, gender, major field of study, and career goals. The entire questionnaire was presented online and took approximately 20 minutes to complete.

Results and Discussion

Mean ethical ratings by major and by case-scenario type are presented in Table 1. A 3x2 mixed design ANOVA was calculated to examine the effects of major (psychology, nursing, and other) and case-scenario type (young and old) on ethical ratings. The main effect for case-scenario type was significant, $F(1, 94) = 23.90, p < .001, \eta_p^2 = .20$. Participants ranked case scenarios involving younger adults as more ethical than case scenarios involving older adults. The main effect for major, $F(2, 94) = .255, p > .05$, and the scenario age x major interaction, were not significant, $F(2, 94) = .206, p > .05$.

Based on Onwuteaka-Philipsen et al.'s (1997) finding of a greater frequency of euthanasia performed with older patients, we had hypothesized a greater acceptance of euthanasia for older patients. Our finding of a greater acceptance for young patients was surprising. However, a closer look at the data of Onwuteaka-Philipsen et al. offers a possible explanation. When Onwuteaka-Philipsen et al. calculated the proportion of euthanasia-related deaths among all deaths occurring in the Netherlands, the proportion was highest in the population ranging in age from 25 to 44. In other words, while it is true that euthanasia is more frequently performed on older adults than on younger adults, the age-association changes when one considers the number of times euthanasia is performed as a proportion of all deaths. Compared to the death of an older adult, the death of a younger adult is more likely to be the result of euthanasia. It may be, then, that euthanasia is considered more acceptable for a terminally ill younger adult than it is for a terminally ill older adult, and the reason euthanasia is performed more often on older adults is that they suffer more from terminal illnesses. It is not clear why euthanasia would be more acceptable for a terminally ill

younger adult. Our participants were all young themselves, and may have been influenced by their own end-of-life wishes. We propose to use the same scenarios in a study with older adults. If there is a general acceptance of euthanasia in young adults, then similar responses would be expected in young and old participants. If, on the other hand, participants respond differently regarding euthanasia in their own or another age group, then we would expect an interaction between scenario age and participant age.

Our results failed to support the hypothesis that ethical ratings would differ depending on the participant's major field of study. It may be that our sample was too homogeneous to show a difference, or that any differences are more likely to appear later in one's education. It would be interesting to replicate this study comparing medical students with those studying for their masters in business, for example. Clearly, the results of our study are limited in generalizability. The participants were college students, all were young adults, and the majority were male. A larger study, with a more diverse sample, could provide valuable information about possible age, gender, and education-level differences in attitudes about euthanasia.

We had hoped to analyze why participants gave the ethical ratings they did. Our expectation was that participants would mention the age of the patient, and that they would make frequent mention of their own religious beliefs. Unfortunately, the data were insufficient for analysis. Few participants offered explanations for their decisions. It is recommended that future researchers provide multiple-choice response options, rather than simply posing an open-ended question, to determine why participants rate various scenarios as ethical or unethical. The

multiple-choice format might encourage a higher response rate.

References

- Aghababaei, N., Farahani, H., & Hatami, J. (2011). Euthanasia attitude: A comparison of two scales. *Journal of Medical Ethics and History of Medicine*, 4(1), 1-6.
- Allen, J. J., Chavez, S. S., DeSimone, S. S., Howard, D. D., Johnson, K. K., LaPierre, L. L., & ... Sanders, J. J. (2006). Americans' attitudes toward euthanasia and physician-assisted suicide, 1936--2002. *Journal of Sociology and Social Welfare*, 33(2), 5-23.
- Caddell, D. P., & Newton, R. R. (1995). Euthanasia: American attitudes toward the physician's role. *Social Science & Medicine*, 40(12), 1671-1681. doi:10.1016/0277-9536(94)00287-4
- Campbell, A., Gillett, G., & Jones, G. (2005). *Medical ethics* (4th ed.). South Melbourne, Australia: Oxford University Press
- Gielen, J., van den Branden, S., & Broeckeaert, B. (2009). Religion and nurses' attitudes to euthanasia and physician-assisted suicide. *Nursing Ethics*, 16(3), 303-318.
- Newham, R. A. (2013). An internal morality of nursing: What it can and cannot do. *Nursing Philosophy*, 14(2), 109-116. doi:10.1111/j.1466-769X.2012.00554.x
- Onwuteaka-Philisen, B. D., Muller, M. T., & van der Wal, G. (1997). Euthanasia and old age. *Age & Ageing*, 26(6), 487.

Appendix

Table 1
Ethical Ratings by Major and Case-Scenario Type

Major	n	<u>Young Adult Case</u>		<u>Old Adult Case</u>	
		<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Psychology	43	3.32	.724	2.97	.658
Nursing	26	3.28	.697	2.83	.767
Other	28	3.30	.853	2.83	.411
Total	97	3.30	.749	2.89	.628

Case-Study Scenarios

1. John, a 26 year old marketing executive, has recently been diagnosed with Leukemia. He has no history of serious illness prior to diagnosis. For the past two years John has battled with his disease seeking treatment and support. At his next appointment he is told his illness is terminal. John announces he can no longer withstand the terrible side effects of the treatment and asks his doctor for aid in ending his life. John's doctor gives him advice and information about his decision, and writes him a prescription for the medication needed to take his life.
2. George, 75 years old, is retired and widowed. His wife passed away 6 months ago unexpectedly. As George's family is large, composed of many children and grandchildren, George feels his life is not complete without his wife present. He has been receiving treatment and living with emphysema, congestive heart failure, and colon cancer for the past ten years. George regularly visits his doctors, but since losing his wife feels there is no reason to continue treatment. At his previous appointment, George desperately pleaded with his doctor to aid him in ending his life. George's doctor provides information and suggestions to him in regards to this topic. After being certain George has made up his mind, his doctor provides him a prescription medication to aid George in taking his life.
3. Elizabeth is a 38 year old woman married with two children in elementary school. As she is driving to work one day her car hits black ice and slides into a ditch. The accident is traumatic, and Elizabeth is left with serious brain damage. She is on life support needing a ventilator and feeding tube. After six months doctors observe no response signals. Elizabeth does not have medical directives in place. Her husband was optimistic Elizabeth would make a recovery, but after waiting so long his view begins to change. He has been avoiding making a decision, but knows he will have to decide soon. The hospital pushes for Elizabeth to be moved or a decision to be made. Ultimately, after discussion with various physicians Elizabeth's husband decides to remove her from life support.
4. Julie's children recently made the decision to move her into a nursing home. Julie is 77 years old and has advancing dementia. As she recognizes her name, she is often confused about what is going on around her. In addition to dementia Julie has severe arthritis in her back and hips. She is miserable and continually reports to the nursing home physicians and psychologist that she is done living. One day while being evaluated by the psychologist Julie states she is in too much pain to carry on and attempts to kill herself. The psychologist consults with the physicians and nursing staff about the incident and suggests following through with Julie's wishes. After thorough discussion and contemplation, the decision made is to continue helping Julie remain comfortable, providing close supervision, and helping her find things in life to live for.
5. Rachel is 28 years old and was diagnosed with multiple sclerosis, MS, five years ago. Her physician has prescribed medications to help slow the progression of the disease. Rachel

has tried multiple techniques to help with her MS including therapies, medication, exercise, diet changes and various other adjustments. In the past year Rachel has experienced severe and painful muscle spasms, loss of vision in her right eye, difficulties speaking and swallowing, and has lost the ability to walk. Rachel is discouraged at the lack of relief her treatments are providing. She decides to stop her medications and therapy sessions even though her doctor advises her to continue treatment.

6. Lou is 88 years old and has had few illnesses in his life. He recently has come down with a severe case of pneumonia, and has been admitted to the hospital. Lou's family is concerned because he has been in the hospital for a week without signs of getting better. After further testing and blood work doctors discover that Lou has stage II lung cancer. In spite of his current condition Lou remains optimistic that he will be able to "defeat" the illness. His family members have continually asked the doctors for updates and a prognosis concerning Lou's condition. After several days, hospital staff meets with the family to discuss recent findings. Lou's family inquires about treatment options because Lou is not a person to give up on a challenge. The doctor involved in Lou's case presents a very negative report, and discourages the consideration of treatment, reasoning that the expenses associated with treatment would be too great in regards to the benefits of prolonging the patient's life. The family is swayed into thinking that Lou is towards the end of his life and hospice care is the most cost efficient solution. Lou is reluctant about forfeiting the idea of treatment, but trusts his family and doctor to make the best decision for his health and finances.