ATTITUDES OF THE ELDERLY TOWARDS EUTHANASIA: A CROSS-CULTURAL STUDY

by

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I declare that the article hereby submitted by me for the Master's Degree in (Clinical Psychology) at the University of the Free State is my own independent work and has not previously been submitted by me to another University/Faculty. I furthermore cede copyright of this article in favour of the University of the Free State.

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ABSTRACT

The purpose of this study was to determine attitudes of the elderly towards euthanasia. The aims of this research study were achieved by gathering data from a number of elderly respondents aged 65 and older at several old age homes in the Bloemfontein area. Six old age homes were involved in this study with a slightly greater concentration coming from Bloemfontein N=89 (44.5%), while the distribution was relatively even across the other two broader residential areas N=55 (27.5%) in Heidedal, and N=56 (28%) in Mangaung. A biographical questionnaire as well as the Euthanasia Attitude Scale was used. The influence of three variables such as, race, religious beliefs and gender, on the attitudes of the elderly people towards euthanasia was investigated. One-way ANOVA analysis was used. After statistical analysis, the variable found to have the greatest influence on the attitudes of the elderly towards euthanasia was race. Other variables, religious beliefs and gender were not found to have a significant correlation to euthanasia.

(Key words: Euthanasia, physician assisted suicide, attitudes, legalization, morality, race, religious beliefs, gender, socio-demographic factors, elderly people)

SAMEVATTING

Die doel van hierdie ondersoek was om bejaardes se houding teenoor genadedood te bepaal. Die doelwitte van hierdie ondersoek is bereik deur inligting van verskeie bejaarde respondente wat 65 jaar en ouer is en in verskeie ouetehuise in die Bloemfontein-distrik woonagtig is, te versamel. Ses outehuise is by hierdie ondersoek betrek. Die grootste groep respondente was van Bloemfontein N=89 (44.5%), terwyl die verspreiding van die ander twee groter residensiële areas redelik eweredig was, naamlik N=55 (27.5%) in Heidedal en N=56 (28%) in Mangaung. Sowel ‘n biografiese vraelys as die *Euthanasia Attitude Scale* is gebruik. Die invloed van drie veranderlikes, naamlik ras, geloofsoortuiging en geslag, op bejaardes se houdings teenoor genadedood is ondersoek. ‘n Eenrigting variansieontleding is gebruik. Na afloop van die statistiese ontleding is gevind dat ras as veranderlike die grootste invloed op bejaardes se houding teenoor

genadedood gehad het. Die ander veranderlikes, onder meer geloofsoortuiging en geslag, het nie beduidend met genadedood gekorreleer nie.

(Sleutelwoorde: Genadedood, geneesheer-ondersteunde selfmoord, houdings, wettiging, moraliteit, godsdienste oortuigings, geslag, sosio-ekonomiese faktore, bejaardes)

TABLE OF CONTENTS

TABLES

1 INTRODUCTION

The progress made in medical science and in the application of medical technology has resulted in people living longer (Conwell & Cox, 1995). For many patients this signifies a prolonged of life. This certainly raises a question of whether such treatment is a benefit or a burden.

Having created a situation in which lives are consistently saved or prolonged by medical intervention we can hardly act as if the process of dying should be left to nature (Mahommed, 1998). According to the latter, simplistic clichés, which might have had more general truth fifty years ago such as “while there is life there is hope” or “killing is killing” are insufficient to deal with the present state of medical knowledge which is capable of keeping damaged patients alive who in the recent past would not have stayed alive at all.

According to Brogden (2001) the increasing elderly population poses many economic and ethical questions for modern society. One of the most current and controversial of these is the debate about euthanasia (Brogden, 2001). According to Brogden euthanasia is most commonly concealed in the home or care institution, a situation which is attracting increasing professional attention.

Today the question “what is euthanasia?” may be answered by a simple phrase “mercy killing” (Peck, 1997). Exactly which words one chooses to include in a definition or description of euthanasia frequently reflects one’s attitude toward the practice (Peck, 1997). According to Browne (1994) proponents of euthanasia use phrases such as, the merciful extinction of life and easing into death, while opponents choose terms like murder and execution.

In an article published by AcaDemon (2004) it was stated that whether euthanasia should be legal is one of the hotly debated questions that revolve around attitudes and choices. It was also mentioned that the controversy regarding the practice of euthanasia is essentially

a controversy about ethics and morality. The debate about euthanasia is a value debate among people who weigh values differently and who also see the nature of the world and the place of humans in that world differently (Brock, 1992). According to Hobbes (1999) the main reasons that the debate about euthanasia has been so hotly debated and contested is because it challenges the value systems of people. It was noted by Deaux, Dane and Wrightsman (1993) that values serve as dimensions of judgment or as abstract standards for decision-making, through which the individual may develop specific attitudes and beliefs. According to Taylor, Peplau and Sears (2003) a concept closely related to attitude strength is value and important attitudes are ones that reflect fundamental values. Such attitudes are highly resistant to persuasion and also show a strong relationship to decision-making and behaviour (Taylor et al., 2003). Although life is clearly an important value, there may be times when life itself is not worth living (Hobbes, 1999).

It was mentioned by LeBaron (1999) that the way people deal with and respond to issues of life, their attitudes and values about life and death, serve to shape the nature of a society. This is why society must attempt to decide what is right, what is ethical conduct for the various actors in communities when faced with death. A person might argue that all available medical technology ought to be brought to bear in the preservation of life, but the pain and financial burdens that family members, patients or society might have to endure could be so great that although the person might want to go on living, it would be in the best interest of the patient, family or of the society that the individual should choose to die (LeBaron, 1999).

2 PURPOSE AND THE NECESSITY OF THE STUDY

While there have been extensive studies about the attitudes of the general community and health professionals towards various forms of euthanasia, research investigating these issues among the elderly is limited.

Like other moral issues, the problem of euthanasia has a long history of philosophical discussion. But seeing that it is also a social phenomenon and that some elderly people

deem themselves as a burden to society, it is imperative to know what their perceptions about euthanasia are. In South Africa the study conducted by Nortjè (2001), failed to prove that culture has a significant effect on a person's views or attitudes regarding euthanasia. The primary aim of this study is therefore to do an investigation into the attitudes of the elderly towards euthanasia. The fact that the current investigation is done cross-culturally will add value to existing results. The influence of a number of independent variables such as gender and religious beliefs will also be investigated, as it is believed that they have a great influence on most individuals' attitudes towards euthanasia.

3 THE NATURE OF ATTITUDES

3.1 Attitude formation

An attitude is a mixture of beliefs and emotions/feelings that predisposes a person to act towards other people, objects or institutions in a positive or negative way (Peplau, Sears & Taylor, 2003). According to Myers (1994) attitudes can be explained as beliefs and feelings that may influence our reaction. There are many routes to attitude formation. Attitudes can be learned through direct reinforcement or acquired through imitation and social learning (Moghaddam, Taylor & Wright 1993).

People can learn by observing the behaviour of others (Dane, Deaux & Wrightsman, 1993). Parents are the earliest and the most evident sources of acquired attitudes (Smith & Mackie, 1995). Peers and the media are also a major influence on how individuals acquire attitudes and their influence can be explained by social learning theory (Peplau et al., 2003).

3.2 Attitude theories

According to Peplau et al. (2003) several theories are helpful for understanding how attitudes are formed. They explained the theories or approaches as follows: According to

the learning approach attitudes are learned. Motivational approaches are based on the principle of cognitive consistency. They give emphasis to the fact that we seek consistency among our attitudes and between attitudes and behaviour, meaning that individuals accept attitudes that fit into their overall cognitive structure. Expectancy-value approaches to attitudes maintain that individuals take on attitudes that maximize their gains. Each side of an issue has costs and benefits; expectancy-value approaches maintain that an individual will adopt the side on which the net gains are greater (Peplau et al., 2003).

The cognitive approach of cognitive response theory considers the conditions that lead us to argue against or passively accept a persuasive communication designed to change our attitudes (Devine, Hamilton & Ostrom, 1994).

3.3 Attitude influence and change

According to Smith and Mackie (1995) the process by which attitudes are formed, reinforced, or changed by communications is known as the domain of persuasion. Persuasive or influential communications attempt to provide information that will make a lasting change in our attitudes (Devine et al., 1994). Peplau et al. (2003) identified a useful model of the persuasion situation that classifies possible influences on the target in terms of the communicator (source), communication, and situational and target variables. They also mentioned that credible, trustworthy, and liked sources are the most persuasive communicators, as are the reference groups with which the target identifies.

4 THE NATURE OF EUTHANASIA

4.1 DEFINITIONS

Euthanasia is a terribly troubling word, meaning literally, according to some, “a good death,” but according to others a morally outrageous death (Fergussen, 1997). According

to Saunders (1994), euthanasia is the act of taking the life, for reasons of mercy, of a person who is hopelessly ill.

A basic distinction is made between two kinds of euthanasia, namely passive and active (Gillett, 1994). Active euthanasia is identical with mercy killing and involves taking direct action to end a life, for example, intentionally giving a person a lethal dose of a drug to end a painful and prolonged period of dying (Oehmichen & Meissner, 2000). Passive euthanasia is allowing a patient to die when he or she could have been kept alive by the appropriate medical procedures (Vere, 1997).

According to Caddell and Newton (1995), active euthanasia can be defined as any treatment initiated by a physician with the intent of hastening the death of another human being who is terminally ill and in severe pain or distress with the motive of relieving that person from great suffering. Passive euthanasia can be defined or considered as discontinuing or not starting a treatment at the request of the patient (Caddell & Newton, 1995).

Further distinction is made between voluntary, involuntary and non-voluntary euthanasia (Gillett, 1994). According to the latter voluntary euthanasia occurs when the decision to terminate life by the physicians corresponds with the patient's desire to do so and the patient willfully gives consent of its implementation. Involuntary euthanasia occurs when the decision to end life is implemented against the patient's wishes (Gillett, 1994). Non-voluntary euthanasia refers to cases where patients are unable to make their wishes known, for example a person who is brain dead and in a permanent or irreversible coma (Gillett, 1994).

According to Muller and Kriegsman (1997) active voluntary euthanasia and physician-assisted suicide are often combined and mentioned in one breath. They defined active voluntary euthanasia as the deliberate termination of life, by someone other than the patient, at the patient's request and physician-assisted suicide as intentionally helping a patient to end his or her life at his or her request.

4.2 MORAL AND LEGAL ASPECTS OF EUTHANASIA

The current and technological advances in life-supporting measures have created significant moral and social dilemmas concerning the appropriateness of applying life-sustaining treatment in specific cases (Mahommed, 1998). The latter mentioned that the question today in many instances is not whether we can prolong life but whether we should.

According to Uhlmann (1998) the euthanasia debate is part of a larger issue concerning the right to die. He mentioned that individuals' attitudes towards euthanasia differ. Those in favour of euthanasia argue that with specific safeguards and in certain circumstances the taking of a human life is merciful and that all of us are entitled to end our lives when we see fit (Uhlmann, 1998). Opponents argue that euthanasia is not an act of mercy and should therefore not be performed (Uhlmann, 1998).

According to Leichtentritt and Retting (1999), the legalization of euthanasia would cause a general weakening of public and social morality. Many doctors in South Africa favour mercy killing (Landman, 2001). According to Landman (2001) a number of doctors in South Africa would be willing to perform euthanasia at the request of their patients once the controversial practice was legalized in the country. He reported that while there is no scientific data available to indicate exactly how many doctors were in favour of euthanasia, or physician assisted suicides informal questionnaires distributed to doctors have shown positive results.

The results published by McLean and Britton (1996) in the United Kingdom (UK) revealed strong support for the legalization of physician-assisted suicide among the medical profession, and the population at large. The study revealed that a majority of medical practitioners (54%) are in favour of changing the law to allow physician assisted suicide in some circumstances, with only 36% of the respondents opposing such a change

and 55% felt that this should be permissible if the person had a terminal condition or was in a state of extreme mental or physical suffering. According to Jowell and Curtice (1996), not only do euthanasia and assisted suicide already have the support of a substantial majority of the UK population, but also this support is actually growing. A 75% majority in favour of permitting medical assistance in the ending of life of a sufferer from a painful, incurable disease in 1984 increased to 79% in 1989, and 82% in 1994 (Jowell & Curtice, 1996).

According to Morgan (1995) 64% of Americans believe that a doctor should be allowed to end the life of a patient who has a painful and terminal disease if that patient wishes to die. In Australia, the figure is even higher, with 78% backing the doctor's right to end the patient's life (Morgan, 1995).

In a journal article published by De Beer and Gastmans (2004) it was reported that since April 2001, the Netherlands has had a legal regulation of euthanasia, making it the world's first country to place euthanasia within a legal framework. In Belgium, after years of debate, the law governing euthanasia came into force on 23 September 2002. Before this date, euthanasia was illegal in Belgium. Euthanasia is illegal in every state of the US, and does not have a prominent place in the debate on the end of life that is conducted in the US (De Beer & Gastmans, 2003). According to Nortjè (2001), South Africa is currently facing proposed changes to the legislation on euthanasia. He reported that the South African Law Commission (SALC) (1997) released a discussion paper suggesting changes to legislation. Their request favours voluntary euthanasia as opposed to the current position, which is anti-euthanasia.

In ethical debates about euthanasia, the focus is often exclusively on the involvement of physicians and the involvement of nurses is rarely given much attention (Young, 1993). The role played by the nurse in carrying out euthanasia can vary from simple presence in person to the actual administration of the lethal medication (Asch, 1996). An American study of the association between the self reported participation of intensive care nurses and their social and professional characteristics showed that older, more religious nurses,

nurses working in cardiology unit, and nurses with less positive attitudes towards euthanasia are less likely to report having cooperated in performing euthanasia (Stevens, 1994). The authors observed that the effect of the sex and religion of the nurses is probably mitigated by attitudes (Asch & Dekay, 1997). Reasons cited by the nurses for performing euthanasia without a physician's authorization include a feeling of responsibility for the patient's wellbeing and the wish to relieve the patient of his or her suffering (Kuhse, 1993).

4.3 FACTORS INFLUENCING ATTITUDES TOWARDS EUTHANASIA

In a study by Baumeister (1991) cited by Nortjè (2001), it was found that attitudes towards euthanasia are more complicated than simply voicing an opinion in favour of or against it and that attitudinal complexity is the result of various factors which have a great influence on most individuals' view of euthanasia. These factors include cultural and religious beliefs, age, gender and socio-demographic factors.

4.3.1 Age

Age has a very strong impact on people's attitudes towards euthanasia**.** According to Brogden (2001), an elderly person with a terminal illness is vulnerable. They may lack the knowledge and skills to alleviate their symptoms, and may well suffer from fear about the future and anxiety about the effect of the illness on others. The elderly person's decision making about euthanasia may be affected by confusion, dementia, depression or other related symptoms, which could be relieved with appropriate treatment and social support (Blank & Robinson, 2001).

Great pressure is experienced by elderly people to request euthanasia because many of them already feel a burden to their families and caregivers (Brogden, 2001). In a study conducted by Sueela (1998) in India to determine the elderly's attitude towards death, the majority were not afraid of death, due to their strong faith in God. About 61.5% of the elderly supported euthanasia, but expressed concern that euthanasia might be misused as

a means of getting rid of invalid elderly persons and avoiding the responsibility of caring for them. In the study conducted by Cicirelli (1998) a significant association between age and the choice for euthanasia was found. It was also reported by Jowell and Catrice (1996) in their study that support for voluntary euthanasia is even stronger among the elderly. According to this report on a study conducted among British pensioners, 92% of the elderly surveyed replied that doctors should be allowed to end the life of terminally ill patients who want to die.

Only a few studies on attitudes towards euthanasia have been conducted in South Africa, with that of Nortje (2001) the most recent one. He found a positive correlation between age and acceptance of euthanasia. The older the adult becomes the more acceptant of euthanasia he or she becomes. According to Moghaddam et al. (1993) in many cultures elderly people are the most powerful figures in the community in influencing attitude change. As the individual grows older, that individual will progress and change ways of thinking and reasoning (Moghaddam, 1993).

4.3.2 Race

Life-prolonging techniques became increasingly available and there were possibly generational and cultural changes in patients' attitudes. According to Cooper-Kazaz, Friendlander, Steinberg et al. (1999), attitudes towards the dying patient and the appropriate treatment approach are based on cultural and emotional factors. It was suggested by Garret and Harris (1993), that black patients are more inclined to choose life-sustaining treatments than white patients. In a study that was conducted by Cicirelli (1998), the findings showed that views of the elderly towards euthanasia are related to ethnicity.

A cross-cultural perspective on any aspect of the attitude process could enrich our understanding in that it could provide insights that reach to the very core of societal

stability (Moghaddam et al., 1993). The first process is the way we express our attitudes toward other people and secondly is attitude change (Moghaddam et al., 1993).

4.3.3 Religion

It is simply assumed that most Christians are united in their opposition to assisted suicide and voluntary euthanasia (Gill, 1998). Although many regular churchgoers apparently agree with legalizing some forms of active euthanasia, most theologians and church leaders remained opposed, says Gill (1998). Some church leaders suggest that to accept that one is not going to get well and therefore to request help to die is an act of faithless misery, a decree of hopelessness, and as such an offence against two of the central theological qualities, faith and hope (Vere, 1997). In the study conducted by Vere (1997) it was reported that Buddhists ideas in relation to euthanasia converge with Christian views.

In South Africa Muslims made a declaration that active euthanasia where patients may end their lives by lethal injection is impermissible under any circumstances and that passive euthanasia where patients may withhold treatment or artificial life-support is only permissible if a trustworthy, reliable opinion and specialist feels that there is no hope of survival (Ulama, 2004).

In their study to determine American attitudes toward the physician's role, Caddell and Newton (1995) found that various religious groups have strong effects on attitudes toward many social, political and moral issues. Protestants have been found to hold different attitudes concerning active euthanasia than Catholics. Among Protestant clergy, 73.2% accepted active euthanasia as a viable option, as opposed to 63.1% of the Catholic clergy. Protestants tended to favour active euthanasia more often than Catholics (Caddell & Newton, 1995). However, research conducted by McLean and Britton (1996) has

revealed that as many as 73% of UK Catholics agree that doctors should be allowed to help an incurably ill patient to die.

In the Netherlands euthanasia is now legal, and some churches there have been hostile to this (Gill, 1998).

4.3.4 Gender

Patients' choices for care in the event of terminal illness relate to a complicated set of demographic, educational and cultural factors (Garret & Harris, 1993). In their study, Garret and Harris (1993) found that women wanted life-sustaining treatments less often than did men. In a study that was conducted by Canneto (2002) about euthanasia and women, when mercy killings occur they are usually administered by men for women, with two-thirds of those being female. She also reported that women are over represented in assisted suicide and euthanasia reports.

Callahan (1999) suggested that women will be affected most by euthanasia simply because they live longer and have fewer resources than men. According to her, countries that have data on poverty by age and sex show that older women are more likely to be poor than older men and therefore favour euthanasia.

4.3.5 Socio-demographic factors

According to Kelly (2003), being admitted to an in-patient hospice setting, perceiving oneself as a greater burden on others, reporting less family cohesion, having fewer social supports and less satisfaction with social supports, being more anxious and experiencing greater impact of physical symptoms represent chief determinants to request euthanasia.

In South Africa Van Vuuren (1984) found that social changes, such as circumstantial changes, have an effect on people's attitudes towards euthanasia.

In the study conducted by Oehmchen and Meisserner (2000), it was argued that economic factors play a role in the individuals' request for euthanasia. They mentioned that as medical treatment at the end of life becomes more than ever expensive, health insurance above all in the USA are beginning to question the economic soundness of providing long-term treatment to terminally ill patients.

According to Caddell and Newton (1995) highly educated, politically liberal people with a less religious self-perception are most likely to accept active euthanasia in the case of a terminally ill patient.

5 SUMMARY

Modern medical technology has made it possible to extend the lives of many far beyond when they would have died in the past. A question has been raised of whether such treatment is a benefit or a burden. From the literature it has been argued that although life is clearly an important value, there may be times when life itself is not worth living. One of the most current and controversial of these is the debate about euthanasia. There are two types of euthanasia, voluntary and involuntary euthanasia. Voluntary euthanasia has been described as a situation in which the person concerned asks someone to help them to die. They may persuade another person to assist them to die or they may refuse to have the medical treatment necessary to be kept alive. Involuntary euthanasia has been described as situation in which the person concerned is no longer in a condition where they can make a decision. The decision to bring about the death of the person is taken by relatives or medical experts. Euthanasia can also be referred to as being 'active' or 'passive'. Active euthanasia has been described as a situation in which a specific action is undertaken to bring life to an end and passive euthanasia as the withdrawal of treatment or the situation in which life support machines are switched off in order to allow the person to die.

As mentioned earlier in the literature, attitudes towards euthanasia are more complicated than simply voicing an opinion in favour of or against it and attitudinal complexity is the result of various factors, which have a great influence on most individuals, view of euthanasia. An attitude has been described as a mixture of beliefs and emotions that predisposes a person to act towards other people, objects and situations in a positive or negative way. Factors that have a great influence on individuals' attitude towards euthanasia include cultural and religious beliefs, age and gender. There have been extensive studies about the attitudes of the general community and health professionals towards various forms of euthanasia, but research investigating these issues among the elderly is limited. Seeing that euthanasia is a social phenomenon and that elderly people deem themselves as a burden to society it is imperative to know what their perceptions about euthanasia are.

6 RESEARCH METHOD

The primary aim of this research was to investigate the attitudes of the elderly towards euthanasia. The investigation was done cross-culturally and the influence of a number of independent variables on the attitudes of the elderly towards euthanasia such as, race, gender and religious beliefs were investigated.

6.1 Formulation of research problem

From the literature on euthanasia it was predicted that peoples' attitudes towards euthanasia would differ in terms of race, gender and religious beliefs. On the other hand not much information on the literature is available which relate to attitudes of the elderly towards euthanasia among different cultures/races or cross-culturally. In the light of the above, it was hypothesized that:

- Elderly persons' attitudes towards euthanasia differ in terms of race/culture, gender and religious beliefs.

6.2 Subjects and data collection

The aims of this research study were achieved by gathering data from a number of elderly respondents at several old age homes in the Bloemfontein area. Six old age homes were identified and permission was obtained from the management to approach the residents. A total of 200 questionnaires were completed. Interviews were also utilized to assist some of the elderly to fill in the questionnaires. Two questionnaires batteries were administered in English and Afrikaans only. For many of the respondents English or Afrikaans is their second or third language and in order to compensate for any possible misunderstandings, each question was explained making use of their own language, for example, South Sotho and also making use of everyday examples the elderly people could understand. Each response was recorded in a written format. No standardised explanations were given and varied between groups being tested. It took the researcher several months to gather the data, as she had no assistance.

Participation in this study was on a voluntary basis and an availability sample was used. The researcher individually interviewed each participant in the privacy of his or her own room to ensure confidentiality and objectivity. No names or any other personal information were recorded.

As can be seen in Table 1, the distribution shows a slightly greater concentration coming from Bloemfontein N=89 (44.5%), while the distribution is relatively even across the other two broader residential areas N=55 (27.5%) in Heidedal, and N=56 (28%) in Mangaung.

Table 1 ***Location of Retirement Homes and Completed Questionnaires***

Area	**N**	**Home**	**n**
Bloemfontein	89	Mooihawe	16
		Stellenryk	32
		Striata	41
Heidedal	55	Omega	33
		Opkoms	22
Mangaung	56	Boikhutso	56
Total	200	Total	200

6.3 Measuring instruments

The measuring instruments consisted of a demographic questionnaire (Appendix A) as well as the Euthanasia Attitude Scale (EAS) developed by Holloway, Hayslip, Murdock et al. (1995) (Appendix B). This scale was developed to assess the general attitude a person has towards end of life decisions.

6.3.1 Euthanasia Attitude scale

The EAS is a 30-item Likert-scale questionnaire, which measures attitudes towards euthanasia. The scale uses both positively (16 items) and negatively (14 items) worded statements to control the effect of acquiescence. The scale also has four response categories, namely “definitely agree”, “agree”, “disagree” and “definitely disagree”. In order to quantify the items, numbers that range from four to one were given to the positive items. Numbers for the negative items have been reversed. The scale provides a total score, which may range between 30 and 120, with scores between 75 and 120 indicating endorsement of euthanasia and scores beneath 75 as an indication of a negative attitude towards euthanasia.

The EAS questions deal with a variety of issues surrounding both active and passive euthanasia, such as the status of brain dead persons, life extending technology, ethics and legal issues (Holloway et al., 1995). According to the latter the questionnaire has excellent psychometric properties, such as, stability, internal consistency, discriminant validity and test-retest reliability. The test was standardised for the American population and the reliability for this specific study using Euthanasia Attitude Scale had an alpha coefficient of 0.55. No data is available verifying the validity of the test cross-culturally.

6.4 Statistical analysis

Analysis of variance (ANOVA) is used to analyse the data. According to Aron and Aron 1994, the statistical procedure used for testing variation among the means of three or more groups is called the analysis of variance (ANOVA). It is a powerful technique for examining the combined influence of one or more independent variables on one or more dependent variables (the latter being known as MANOVA). Specifically, a factorial ANOVA allows the researcher to investigate the individual and combined (interaction) effects of any number of independent variables on a single dependent variable.

7 RESULTS

7.1 Sample Characteristics

The sample consisted of 83 (41.5%) males and 117 (58.5%) females. The gender distribution according to age and race is shown in Table 2 and Table 3 respectively.

Table 2 ***Gender Across Age Groups***

		Age					
		65-69	**70-74**	**75-79**	**80-84**	**85+**	***Totals:***
Gender	***Male***	20	27	23	9	4	*83*
	Female	29	35	32	17	4	*117*
	Totals:	*49*	*62*	*55*	*26*	*8*	*200*

Table 3 ***Gender Across Race Groups***

		Race			
		African	***Coloured***	***White***	***Totals:***
Gender	***Male***	28	16	39	*83*
	Female	35	32	50	*117*
	Totals:	*63*	*48*	*89*	*200*

The race of the various respondents is shown in Table 4, together with the distribution of races across the various retirement homes. The racial distribution shows that the largest part of the sample was Whites N=89 (44.5%), with N=63 (31.5%) Black Africans, and N=48 (24%) Coloureds.

Table 4 ***Race Distributions Across Old age Homes***

Race	Retirement Home						
	Mooihawe	***Stellenryk***	***Striata***	***Omega***	***Opkoms***	***Boikhutso***	***Totals:***
African	0	0	0	8	0	55	*63*
Coloured	0	0	0	25	22	1	*48*
White	16	32	41	0	0	0	*89*
Totals:	*16*	*32*	*41*	*33*	*22*	*56*	*200*

All the participants were from a Christian background, although the precise doctrinal stream and denominations they belonged to varied. The various denominations and their spread across the various race groups are shown in Table 5.

Table 5 ***Race Distribution Across Religious Persuasion***

		Race			
Religious Persuasion	**Denomination**	***African***	***Coloured***	***White***	***Totals:***
Catholic	***Roman Catholic***	20	5	13	*38*
	Anglican	9	2	0	*11*
Evangelical	***Protestant***	13	15	60	*88*
	Lutheran	1	1	0	*2*
	Baptist	0	1	1	*2*
	Dutch Reformed Church (N.G Kerk)	4	6	13	*23*
	Methodist	5	4	0	*9*
Charismatic	***Full Gospel***	2	0	0	*2*
	Christian Revival Church	1	3	0	*4*
	Apostolic Faith Mission	0	3	2	*5*
Christian other	***12 Apostolic Church***	2	7	0	*9*
	Zion Christian Church	6	1	0	*7*
	Totals:	*63*	*48*	*89*	*200*

Table 6 shows the various language groups included in the study, as well as their distribution across race lines. Afrikaans was by far the predominant language, with N=135 (67.5%) of the sample. Next was Sotho N=53 (26.5%), with Xhosa N=9 (4.5%), Zulu N=2 (1%) and German N=1 (0.5%) forming minority groups in the sample.

Table 6 ***Race Distribution Across Language***

		Race			
		African	***Coloured***	***White***	***Totals:***
Language	***Afrikaans***	0	47	88	*135*
	German	0	0	1	*1*
	Sotho	52	1	0	*53*
	Xhosa	9	0	0	*9*
	Zulu	2	0	0	*2*
	Totals:	*63*	*48*	*89*	*200*

7.2 Reliability

The reliability of the EAS was assessed using listwise deletion of all missing data. In total, the Cronbach's alpha could be computed (N=179) at .948. The reliability for each subgroup or race was satisfactory. The Cronbach's alpha for Africans could be computed (N=61) at .960, for Coloureds (N=46) at .882 and for Whites (N=72) at .915).

7.3 Analysis of variance

In this study, an ANOVA was conducted with race, gender and religion as independent variables. Although different age groups were identified, age was not included in the ANOVA due to the small frequencies in some of the cells. Because the respondents belonged to a total of 17 different denominations, this was deemed to be too great a division for sensible use in the ANOVA (due to the small cell sizes resulting from such a division). As such, the various denominations were grouped into four broader doctrinal groups: Catholic; Evangelical; Charismatic; and Christian sects (Table 8).

Table 7 *Denomination and Doctrinal Stance*

		Doctrinal Stance				*Totals:*
		Catholic	*Evangelical*	*Charismatic*	*Christian sects*	
Denomination	***Roman Catholic***	38	0	0	0	*38*
	Protestant	0	88	0	0	*88*
	Zion Christian Church	0	0	0	7	*7*
	Dutch Reformed (N.G. Kerk)	0	23	0	0	*23*
	Methodist	0	9	0	0	*9*
	Apostolic	0	0	0	9	*9*
	Lutheran	0	2	0	0	*2*
	Baptist	0	2	0	0	*2*
	Anglican	11	0	0	0	*11*
	Full Gospel	0	0	2	0	*2*
	Christian Revival Church	0	0	4	0	*4*
	Apostolic Faith Mission	0	0	5	0	*5*
Total		*49*	*124*	*11*	*16*	*200*

The results of the Anova are shown in Table 8. As is evident from this table, only one effect was significant, viz. Race.

Table 8 *Factorial Anova for Race, Gender and Doctrinal Stance*

		Sum of Squares	**df**	**Mean Square**	**F**	**Sig.**
Main Effects	**(Combined)**	12210.619	6	2035.103	13.016	0.000
	Race	8989.214	2	4494.607	28.747	0.000
	Gender	529.623	1	529.623	3.387	0.067
	Doctrinal Stance	129.804	3	43.268	0.277	0.842
Model		12210.619	6	2035.103	13.016	0.000
Residual		30175.361	193	156.349		
Total		42385.98	199	212.995		

**p<0.01

However, since there were three different race groups in the sample, determining what the differences between them were required the performing of a one-way Anova, with a post-hoc Scheffé test. This test allows the researcher to test the significance of the comparison between each combination of means from each level of the independent variable, while containing the Type-I error rate. The Anova results are shown in Table 9, and the Scheffé test results in Table 10.

Table 9 ***One-way Anova for Race***

	Sum of Squares	**df**	**Mean Square**	**F**	**Sig.**
Between Groups	11564.789	2	5782.395	36.959	0.000
Within Groups	30821.191	197	156.453		
Total	42385.98	199			

**p<0.01

Table 10 ***Scheffé Test Results for One-way Anova of Race***

	Mean Differences			
	African	**Coloured**	**N**	**Mean**
African			63	58.7619
Coloured	-6.42560(*)		39	65.1875
White	-17.31675(**)	-10.89115(**)	53	76.0787

* p<0.05

**p<0.01

As is evident in Table 10, Black Africans were the least accommodating of euthanasia (as evidenced by their lower mean score on the EAS) than both Coloureds and Europeans, and Coloureds were also significantly less accommodating than Europeans.

8 DISCUSSION

8.1 Introduction

The purpose of this study was to investigate the attitudes of the elderly people towards euthanasia. The independent variables such as race, religious beliefs and gender were included in the study to determine their influence on the participants' attitudes towards euthanasia.

8.2 Race

The main finding of this project is that race is a very important variable when elderly people's attitudes towards euthanasia are investigated. Elderly Black Africans seem to be the least accommodating of euthanasia than both elderly Coloureds and elderly Europeans. Elderly Coloureds were also significantly less accommodating than elderly Europeans. This means that the hypothesis for race that was stated in 6.1 could be retained.

The results of this study are in accordance with the idea of Cooper-Kazaz et al. (1999) that when life-prolonging techniques became increasingly available there were generational and cultural changes in patients' attitudes. They mentioned that attitudes towards the dying patient and the appropriate treatment approach are based on cultural and emotional factors.

The finding is also in accordance with Garret and Harris (1993), who suggested that black patients are more inclined to choose life-sustaining treatments than white patients. In a study that was conducted by Cicirelli (1998) to investigate views of the elderly people concerning end-of-life decisions, the findings showed that views of the people

towards euthanasia are related to ethnicity. However there is little literature available which relate to cross-cultural investigations into the attitudes of people towards euthanasia.

In the South African study conducted by Nortjè (2001) no statistically significant differences in the attitudes of people from different races were found.

8.3 Religion

That religion proved not to be significant may be more as a result of the way in which it was measured in this study than an indication that it has no relationship to attitudes towards euthanasia. All the respondents came from a Christian background, and the only difference was in denomination. The "religion" variable in this study thus served to differentiate only between broad doctrinal lines within Christianity. It may just be that all of these broader groupings, while sometimes holding vastly different opinions on some matters (e.g., homosexuality), do agree on the issue of euthanasia. As such, the restriction in range of the measurement of religion (to only Christians) may have resulted in it not being significant. It remains for further studies to determine whether it would be significant or not should adherents of other religions (e.g., Buddhism, Hinduism, Islam, etc.) be included in the sample.

The present study's findings differ from several investigations. In their study to determine American attitudes toward the physician's role, Caddell and Newton (1995) found that various religious groups have strong effects on attitudes toward many social, political and moral issues. Protestants have been found to hold different attitudes concerning active euthanasia than Catholics. Among Protestant clergy, 73.2% accepted active euthanasia as a viable option, as opposed to 63.1% of the Catholic clergy. Protestants tended to favour active euthanasia more often than Catholics (Caddell & Newton, 1995). However, research conducted by McLean and Britton (1996) has

revealed that as many as 73% of UK Catholics agree that doctors should be allowed to help an incurably ill patient to die.

8.4 Gender

Gender also did not produce statistically significant differences in elderly attitudes towards euthanasia. This differs from Canneto (2002) who mentioned that women are often over represented in assisted suicide and euthanasia reports. A descriptive analysis released by Canneto (2002) of 69 people who died with the assistance of a doctor in Oregon, showed that between 1990 and 1998 71% of the victims were women. She mentioned that 43% of the women were divorced compared with 15% of the men. In Oregon, women are increasingly receiving assisted suicide. In 1998, 50% were female; in 1999, 41%; and in 2001, 62% (Canneto, 2002).

As far as religion and gender are concerned the hypothesis stated in 6.1 should be rejected.

9 CONCLUSION

The results of this present study showed that race has a significant effect on the elderly people's attitudes towards euthanasia. Elderly Black Africans seem to be the least accommodating of euthanasia than both elderly Coloureds and elderly Europeans. Elderly Coloureds were also significantly less accommodating than elderly Europeans. As mentioned earlier a cross-cultural perspective on any aspect of the attitude process could enrich our understanding in that it could provide insights that reach to the very core of societal stability (Moghaddam et al., 1993).

This study failed, however to prove that gender has a significant effect on elderly people's attitudes towards euthanasia despite evidence from the literature that indicates the opposite.

While religion may play an important role in determining attitudes of individuals towards euthanasia, the findings from this study did not indicate it to have a significant effect on attitudes of the elderly people towards euthanasia. All the respondents came from a Christian background, and the only difference was in denomination. The "religion" variable in this study thus served to differentiate only between broad doctrinal lines within Christianity. It may just be that all of these broader groupings, while sometimes holding vastly different opinions on some matters (e.g. homosexuality), do agree on the issue of euthanasia. As such, the restriction in range of the measurement of religion (to only Christians) may have resulted in it not being significant. It remains for further studies to determine whether it would be significant or not should adherents of other religions (e.g. Buddhism, Hinduism, Islam, etc.) be included in the sample. However, literature indicated that Protestants have been found to hold different attitudes concerning active euthanasia than Catholics while initially it was assumed that Christians are united in their opposition to assisted suicide and voluntary euthanasia.

As mentioned earlier in the literature the controversy regarding the practice of euthanasia is essentially a controversy about ethics and morality. The main reasons that the debate about euthanasia has been so hotly debated and contested is because it challenges the value systems of people. The way people deal with and respond to issues of life, their attitudes and values about life and death, serve to shape the nature of a society. This is why society must attempt to decide what is right, what is ethical conduct for the various actors in communities when faced with death. It has also been argued that all available medical technology ought to be brought to bear in the preservation of life, but the pain and financial burdens that family members or society might have to endure could be so great that although the person might want to go on living, it would be in the best interest of the family or of the society that the individual should choose to die (LeBaron, 1999). It is therefore of the utmost importance that research in the field of euthanasia/end-of-life

decisions is increasingly carried out especially the influence of socio-economic factors on the attitudes of individuals towards euthanasia seeing that financial implications seem to play a role.

10 SHORTCOMINGS

The first shortcoming encountered is that the questionnaires were administered in English and Afrikaans only. For many of the respondents English or Afrikaans is their second or third language. In order to compensate for any possible misunderstandings, each question was explained making use of everyday examples the elderly people could understand. No standardised explanations were given and varied between groups being tested. In addition to this, the measuring instruments used have not been standardised for the South African population. This could affect the result's validity and reliability.

In addition, the fact that this study was only conducted on urban elderly people in the Free State makes it difficult to determine whether these results are truly representative of the nation's elderly people. It may be argued that the elderly people from urban areas may be more or less conservative than elderly people from other provinces or from rural areas in the country respectively.

Another shortcoming of this study is that it does not look at differences within cultural groups. For example, differences between English and Afrikaans elderly people were not investigated. There are also differences between black ethnic groups such as Zulu, Tswana and Xhosa, which were not investigated.

11 RECOMMENDATIONS

In order to counter the above-mentioned problems, it is recommended that further research should be done and the study should incorporate elderly people from different provinces, as well as from both rural and urban areas. The study should involve a larger sample, if possible all the provinces. Measuring instruments would have to be standardised and the elderly people should preferably be able to complete the questionnaires in their first language.

The restriction in range of the measurement of religion (to only Christians) may have resulted in it not being significant. It remains for further studies to determine whether it would be significant or not should adherents of other religions (e.g. Buddhism, Hinduism, Islam, etc.) be included in the sample. Differences within cultural groups would have to be investigated since different groups have different morals and values concerning life and dying.

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Appendix A

UNIVERSITY OF THE FREE STATE

DEMOGRAPHIC INFORMATION

Respond to each of the following by encircling the preferred number in the column:				**Office use only**
1	Gender:	Male	1	
		Female	2	1-2
2	Age:	65-69	1	
		70-74	2	
		75-79	3	
		80-84	4	
		85+	5	3-7
3	Language:	Afrikaans	1	
		English	2	
		Sotho	3	
		Other	4	8-11
4	Ethnic origin:	African	1	
		Coloured	2	
		European	3	12-14
5	Religious Belief:	Roman Catholic	1	
		Protestant	2	
		Jew	3	
		Muslim	4	
		Buddhist	5	
		African (Zionism)	6	
		Agnostic	7	
		Atheist	8	
		Other (Specify_____)	9	15-23
6	Health:	Excellent	1	
		Good	2	
		Fair	3	
		Poor	4	
		Terminally ill	5	24-28

UNIVERSITEIT VAN DIE VRYSTAAT

Biografiese Vraelys

Omkring die mees gepaste antwoord:				**Kantoor gebruik**
1	Geslag:	Manlik	1	
		Vroulik	2	1-2
2	Ouderdom:	65-69	1	
		70-74	2	
		75-79	3	
		80-84	4	
		85+	5	3-7
3	Taal:	Afrikaans	1	
		Engels	2	
		Sotho	3	
		Ander	4	8-11
4	Etniese oorsprong:	Afrikaan	1	
		Kleurling	2	
		Europees	3	12-14
5	Geloof:	Rooms-Katoliek	1	
		Protestant	2	
		Joods	3	
		Moslem	4	
		Boeddhis	5	
		Afrika-kerk (bv. Sionis)	6	
		Agnostiek	7	
		Atèis	8	
		Ander (_____)	9	15-23
6	Gesondheid:	Uitstekend	1	
		Goed	2	
		Gemiddeld	3	
		Sleg	4	
		Terminaal siek	5	24-28

Appendix B

Euthanasia Attitude scale

The following items are designed to measure the attitudes of persons towards euthanasia. Euthanasia can be defined as acting to terminate or failing to act in such a way as to extend the life of persons who are hopelessly sick or injured for reasons of mercy.

Read each statement carefully; **select one** of the four responses (where 1= strongly agree and 4= strongly disagree) what most closely represents your own attitude toward the statement content by encircling the appropriate number.

		Strongly agree	**Agree**	**Disagree**	**Strongly disagree**	**Office use only**
1.	Even if death is positively preferable to life in the judgment of a terminal patient, no action should be taken to induce the patient's death.	1	2	3	4	29
2.	Under any circumstances I believe that the physicians should try to prolong the lives of their patients.	4	3	2	1	30
3.	To me there is no justification for ending the lives of persons even though they are terminally ill.	1	2	3	4	31
4.	Some patients receive "comfort measures only" (for example, pain relieving drugs) and are allowed to die in peace without further life extending treatment. This practice should be prohibited.	1	2	3	4	32
5.	I believe it is more humane to take the life of an individual who is terminally ill and in severe pain than allow him/her to suffer.	4	3	2	1	34
6.	An individual who is "brain dead" should be kept alive with proper medical care.	1	2	3	4	35
7.	I believe that a person with a terminal and painful disease should have the right to refuse life-sustaining treatment.	4	3	2	1	36
8.	I bear no ill feelings toward a person who hasten the death of a loved one to spare the loved one further unbearable pain.	4	3	2	1	37
9.	I believe there should be legal avenues by which an individual could pre-authorize his/her own death incase intolerable illnesses arise.	4	3	2	1	38

		Strongly agree	Agree	Disagree	Strongly disagree	Office use only
10.	I cannot envision any medical circumstance in which the termination of life would be merciful.	1	2	3	4	39
11.	I would support the decision to reject additional treatments if a dying person contracts a secondary disease that is sure to bring about a quick and painless death.	4	3	2	1	40
12.	I would not support a doctor's decision to reject extraordinary measures if a patient has no chance of survival.	1	2	3	4	41
13.	I support the decision to provide "comfort measures only" if a terminally ill patient is dying and has but a few hours of life left.	4	3	2	1	42
14.	If I were faced with the prospect of a having a loved one suffer a slow and painful death, I would support his/her decision to refuse medical life-sustaining treatment.	4	3	2	1	43
15.	To me it is an act of mercy to a living but "brain dead" person to turn off the life sustaining machines.	4	3	2	1	44
16.	If I were faced with the situation of suffering a slow and painful death, I should have the right to choose to end my life in the fastest and easiest way possible.	4	3	2	1	45
17.	It is cruel to prolong intense suffering for someone who is mortally ill and desires to die.	4	3	2	1	46
18.	No one, including medical professionals, should be allowed to decide to end a suffering person's life.	1	2	3	4	47
19.	To me, anyone who assists a suffering and a terminally ill person to die is nothing but a common murderer.	1	2	3	4	48
20.	A terminally ill person who is in severe pain deserves the right to have his/her life ended in the easiest way possible.	4	3	2	1	49
21.	If a friend of mine were in severe pain, close to death, and begged me to try to convince the doctors to end his/her life mercifully I would I would ignore his plea.	1	2	3	4	50
22.	The injection of a legal dose of some drug to a person in order to prevent that person from dying an unbearably painful death is unethical.	1	2	3	4	51

		Strongly agree	Agree	Disagree	Strongly disagree	Office use only
23.	No matter how much a person can plead for death to avoid unbearable pain, no one should assist the person to accomplish his/her wish	1	2	3	4	52
24.	Inducing death for merciful reasons is acceptable.	4	3	2	1	53
25.	Terminally ill patients who try to starve themselves to death to avoid unbearable pain should be forcefully fed intravenously.	1	2	3	4	54
26.	For me it is unethical to allow termination of a human life when medical technology is able to preserve it.	1	2	3	4	55
27.	The termination of a person's life, done as an act of mercy, is unacceptable to me.	1	2	3	4	56
28.	Assisting a person, who faces a future life of unbearable pain, to end his/her life is murder as I see it.	1	2	3	4	57
29.	One should have the right to choose to die if he/she is terminally ill and is suffering.	4	3	2	1	58
30.	A terminally ill individual should be allowed to reject life support system.	4	3	2	1	59

Genadedoodhoudingskaaal

Die volgende vrae is saamgestel om die houdigs van die persone teenoor die praktyk van "genadedood" te meet. Ons defineer genadedood as 'n aksie wat daarop gemik is om lewe te beëindig, of die gebrek aan aksie wat die lewe van persone wat terminaal siek of ernstig beseer is, kan verleng, met die doel om genade te betoon.

Lees elke stelling noukeurig, kies die een uit die vier kategorieë (waar 1= stem beslis saam en 4=stem beslis nie saam nie) wat u houding teenoor die stellinginhoud die beste verteenwoordig.

		Stem beslis saam	**Stem saam**	**Stem nie saam nie**	**Stem beslis nie saam nie**	**Kantoor gebruik**
1.	Selfs al is die dood volgens 'n terminale pasiënt verkieslik bo die lewe, behoort geen aksie geneem te word om die pasiënt se dood teweeg te bring nie.	1	2	3	4	29
2.	Ek glo dat dokters onder alle omstandighede moet poog om die lewens van hulle pasiënt te verleng, ongeag die omstandighede.	4	3	2	1	30
3.	Daar is volgens my absoluut geen regverdiging vir die beëindiging van mense se lewens nie, selfs nie al is hulle terminal siek nie.	1	2	3	4	31
4.	Sommige pasiënte "word slegs gemaklik gemaak" (byvoorbeeld, ontvang pynverligtende middels) en word toegelaat om in vrede te sterf sonder dat verdere lewensverlengende behandeling toegepas word. Hierdie praktyk behoort verbied te word.	1	2	3	4	32
5.	Ek glo dit is mensliker om iemand wat terminal siek is en erge pyn ly se lewe te neem as om toe te laat dat hy/sy ly.	4	3	2	1	34
6.	'n Persoon wat "breindood" is, behoort lewend gehou te word deur toepaslike mediese ingryping.	1	2	3	4	35
7.	Ek glo dat 'n persoon met 'n terminale en pynvolle siekte die reg behoort te hê om lewensonderhoudende behandeling te weier.	4	3	2	1	36
8.	Ek het geen kwade gevoelens teenoor 'n persoon wat die dood van 'n geliefde verhas om hom/haar verdere ondraaglike fisiese pyn te spaar nie.	4	3	2	1	37
9.	Ek glo daar behoort wetlike kanale te wees waarvolgens 'n persoon magtiging kan gee vir sy/haar dood in geval van ondraaglike siekte.	4	3	2	1	38
10.	Ek kan my nie enige mediese omstandigheid voorstel waar die beëindiging van lewe genadig sal wees nie.	1	2	3	4	39

		Stem beslis saam	Stem saam	Stem nie saam nie	Stem beslis nie saam nie	Kantoor gebruik
11.	Ek sou die besluit om aanvullende behandeling te verwerp ondersteun waar ‘n sterwende persoon ‘n tweede siekte opdoen wat verseker ‘n vinnige en pynlose dood sal meebring.	4	3	2	1	40
12.	Ek sou nie my ondersteuning gee aan ‘n dokter se besluit om buitengewone pogings aan te wend waar ‘n pasiënt in elk geval geen kans op oorlewing het nie.	1	2	3	4	41
13.	Ek ondersteun die besluit om ‘n terminaal siek persoon wat sterwend is en enkele ure oor het om te lewe “slegs te gemaklik te maak”.	4	3	2	1	42
14.	Sou ‘n situasie onstaan waar ek ‘n geliefde ‘n stadige en pynvolle dood moet sien sterf, sou ek sy/haar besluit om lewensonderhoudende medikasie te weier, ondersteun.	4	3	2	1	43
15.	Vir my is dit ‘n gebaar van genade om die lewensonderhoudende masjiene af te skakel van ‘n lewende, maar breindood persoon.	4	3	2	1	44
16.	As ek ‘n stadige, pynvolle dood moes sterf, sou ek die keuse wou hê om my eie lewe te beëindig op die vinnigste en maklikste manier moontlik.	4	3	2	1	45
17.	Dit is wreed om intense lyding van ‘n persoon wat terminaal is en vra om te sterf, te laat voortsloer.	4	3	2	1	46
18.	Geen persoon, insluitende professionele mediese personeel, behoort toegelaat te word om te besluit om ‘n lydende persoon se lewe te beëindig nie.	1	2	3	4	47
19.	Vir my is enige persoon wat ‘n lydende, terminaal siek persoon help om dood te gaan, niks anders as ‘n moordenaar nie.	1	2	3	4	48
20.	‘n Terminaal siek persoon wat in baie pyn is, behoort die reg te hê om te besluit om sy/haar lewe op die maklikste manier moontlik te beëindig.	4	3	2	1	49
21.	Sou ‘n vriend wat erge pyn ly en sterwend is, my smeek om die dokters te oortuig om sy/haar lewe op ‘n genadige manier te beëindig, sou ek hom/haar ignoreer.	1	2	3	4	50
22.	Dit is oneties om ‘n persoon te help om ‘n ondraaglike, pynvolle dood te vermy deur hom/haar met ‘n dodelike dosis medikasie in te spuit.	1	2	3	4	51

		Stem beslis saam	Stem saam	Stem nie saam nie	Stem beslis nie saam nie	Kantoor gebruik
23.	Maak nie saak hoe baie 'n persoon pleit om vroeër te sterf om ondraaglike pyn te voorkom nie, niemand behoort die persoon by te staan en te help om sy/haar wens uit te voer nie.	1	2	3	4	52
24.	Om die dood te versnel uit genade is aanvaarbaar.	4	3	2	1	53
25.	Terminaal siek pasiënte wat hulself uithonger te einde die ondraagblike pyn van die dood te voorkom, moet met mag binne-aars gevoed word.	1	2	3	4	54
26.	Ek beskou dit as oneties om toe te laat dat menslike lewe beëindig word waar mediese tegnologie dit kan onderhou.	1	2	3	4	55
27.	Ek beskou die beëindigig van 'n persoon se lewe, selfs al is dit uit genade, as onaanvaarbaar.	1	2	3	4	56
28.	Volgens my is dit moord om iemand te help om sy lewe te beëindig, al staar die persoon ondraaglike pyn in die gesig.	1	2	3	4	57
29.	'n Persoon behoort die reg te hê om te besluit om sy/haar lewe te beëindig indien hy/sy terminal siek is en ly.	4	3	2	1	58
30.	'n Terminaal siek persoon behoort die reg te hê om die pogings om sy/haar lewe te onderhou van die hand te wys.	4	3	2	1	59