An Attitudinal Survey of Euthanasia in Windward Oahu

A Cross-Sectional Pilot Study of Four Age Groups

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Exploring the attitudes of 185 respondents toward euthanasia, this 1990 cross-sectional pilot study utilized 12 survey questions addressing participants' demographic profiles and 18 focusing on: abortion; capital punishment; euthanasia; sterilization; and suicide. Cross-tabulation of structural, behavioral and attitudinal variables revealed age and education were the key factors in this study's finding that the greater a person's life experience, the more favorable one's attitude toward euthanasia.

To the ancient Greeks, "euthanasia," meant to die easily or happily, with dignity. Today it is generally defined as the voluntary termination of one's life,[1] or more particularly, putting to death painlessly or allowing to die those who suffer from an incurable disease or condition.[2] Benign as these descriptions may seem to some, the issue of euthanasia, like abortion and capital punishment is controversial and poses an ongoing struggle legally, morally and spiritually.[3] Even complex categorization through qualifying terms like "active," "passive," "voluntary" and "involuntary," do little to unite views on this explosive subject.[4]

The significance of this social concern is evidenced in the attention the subject draws in broadcast and print media. In addition to highly visible cases such as Dr Jack Kevorkian, periodicals throughout the U.S. are exploring myriad aspects of this controversial issue.[5] The range of emotional responses expressed by proponents and opponents, indicates that euthanasia can be a key element in studying societal attitudes toward aging, death and dying.

Given current levels of life expectancy, people of all demographic characteristics are facing choices in life-sustaining medical treatment for themselves and their loved ones. The search for individual and collective answers has led to in-depth examination of examples of past social acceptance of both active and passive euthanasia.[6]

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Historical Context

In ancient Greek society, euthanasia was a standard practice, particularly among the elderly. Aged individuals, feeling they were no longer beneficial to society, might gather for one last celebration and then drink hemlock.[7] At the other end of life's spectrum, newborn babies were routinely examined to determine their physical worthiness. If a flaw was found, or the parents were judged to be inferior themselves, the child was killed in order to keep society free from potentially weak and non-contributing individuals.

Euthanasia was also practiced within some Native American cultures, such as the Inuit, Plains Indians and the Apache. Within these groups, the infirm and aged were sometimes left to die when they were too weak to care for themselves, or could no longer tangibly contribute to their society.[8]

In modern American society, however, high value is placed on extending one's life as long as possible. The reasoning is that all human life is valuable and meaningful. Such a focus has led to a medical technology dedicated to sustaining physical life regardless of the expense or suffering involved. In view of today's rising medical costs, (and the insurance necessary to pay for it) many segments of the private and public sectors are now considering various factors involved with aging and death.[9]

A study of 1200 health care workers showed visible attitudes regarding the subject, with more than 65% of its respondents being anti-euthanasia and 35% being pro-euthanasia. Of the 65% against euthanasia, most were nurses' aides and licensed practical nurses. The 35% favoring euthanasia were primarily doctors and registered nurses. The difference in attitudes shown by these results indicate that education and experience do appear to be factors in participant conclusions.[10]

Several anthropological and sociological studies address euthanasia within broader contexts. A study of a 163-member Xhosa-speaking African tribe explored thoughts about death and dying.[11] Respondents expressing the least fear of death were both older and less educated respondents; for it was the younger people who had the greater opportunity for education. Thus it was not possible, in this sample, to separate the effects of age and education from the reactions to fear of death or euthanasia.

In Columbia, Missouri, a study of abortion,[12] shows comparisons between 232 members of the Missouri Citizens for Life (MCL) and 282 members of the Abortions Rights Alliance (ARA). Members of the ARA were more inclined to favor equality of the sexes, especially in their approval of the Equal Rights Amendment. They were more politically liberal and more committed to free speech for social deviants. MCL members were much more conservative in their approach to matters of personal morality and regarded suicide and euthanasia as more objectionable than did their ARA counterparts.

In a 1987 study of abortion, researchers demonstrated that education has a significant effect in the polarization of attitudes.[13] In this case, the greater a group's education, the greater their likelihood of consistently approving of legalized abortion. Adults with a grade school education were the least likely to consistently approve of legalized abortion, while college graduates were the most likely to consistently approve.

Hawaii Living Will Legislation

In Hawaii an initial living will law was passed in 1986.[14] Following years of reconceptualization and debate, the revised statute contained the following elements:

1. A clear statement of the conditions under which life-sustaining medical treatment can be withdrawn. Unique among U.S. state laws, Hawaii permits advance directives from both terminal patients and those who have permanently lost the ability to communicate medical treatment decisions to their physicians.
2. A living will model that may be amended to individual preferences, providing the signer includes a specific check-off stating whether the person making the living will wants to have their life prolonged by tube or other artificial feeding or fluids.
3. Unlike more stringent laws in other states, Act 321 allows verbal or anecdotal evidence as well as written living wills.[15]

This legislative revision resulted from a coalition of legislative, legal and medical authorities concerned with imprecision in the original statute.[16] Expected negative response from Right-to-Life-Movement advocates, was overwhelmed by the oral and written testimony of governmental and professional organizations voicing support of this Act, including: American Civil Liberties Union of Hawaii; the Roman Catholic Diocese of Honolulu; the Hawaii Federation of Physicians & Dentists; Hawaii Health Care Association; Hawaii Long-Term Care Association; Hawaii Medical Association; Hawaii State Department of Health. [17]

In 1992, the effectiveness of the Living Will Law in Hawaii was further strengthened by passage of an act providing for the Durable Power of Attorney for Health Care Decisions.[18] As an amendment to the 1989 Durable Power of Attorney Act, this law allows a person to appoint someone to make health decisions for them, if their own decisions cannot be determined. Documents combining the language of a living will and a durable power of attorney for health care are now routinely provided by attorneys in the State of Hawaii.

Attorney Jeff Crabtree was a key proponent of these statutory amendments. He was propelled to an activist position by the experience of his mother who became comatose following an accident in 1986.[19] With initial controversy within the family, and the ambiguous position of the 1986 law, Crabtree faced constructing a legally-acceptable argument for obtaining suspension of all life support aids to his mother.[20]

Even with the eventual agreement by all family members, the process was arduous and expensive. Finally, after four and a half years, the State of Hawaii ruled that the mechanical life support systems could be disconnected and she would be allowed to die with dignity.[21]

Focus

As of 1991, little national attention had been focused solely on euthanasia. The primary study to focus solely on attitudes regarding euthanasia was designed and administered in 1977 by sociologists David Jorgenson and Ron Neubecker.[22] In their four-point response measurement they found that of the 1525 people surveyed, 50% were opposed to euthanasia. Seventy percent of white males were pro-euthanasia, contrasted to blacks and females who tended to be against euthanasia. The highest income group was also shown to be pro-euthanasia, as were those with the most seniority and education.

The latter two variables were the focus of the design and implementation of this sampling of societal views toward euthanasia. It compares attitudinal differences among: high school; college; working; and, retired persons. Specifically, this study sought to find whether the variables of age and education were measurably significant. It is hypothesized that life experience, as measured through age and education, tends to reflect a person's stand on euthanasia, with the older and more educated tending to reflect a more neutral or pro-euthanasia attitude.

Method

This cross-sectional study of four age groups sampled on the windward side of Oahu, Hawaii explores attitudes toward euthanasia with a 30-question survey of 185 people. The first 12 questions addressed the demographic profile of respondents. The remaining 18 questions focused on views of health and life including abortion, capital punishment, euthanasia, societal imposition of sterilization, and suicide.

Five areas of the opinion survey delineate the pro-euthanasia and the anti-euthanasia groups. The hypothesis is: The greater a person's life experience is (based on age and education), the more favorable will be his or her attitudes toward euthanasia. Structural, behavioral and attitudinal variables were cross-tabulated to measure the relationship between these variables.

Analysis of results concluded variables of religious and political affiliation and activism are not significant determinants of respondents' overall reaction to the concept of euthanasia. Age and education are found to be the two key relevant variables in this study.

Sample

The data base for this research draws on a total sample of 185 people in four research subgroups: students at James B. Castle High School; students of the University of Hawaii at Windward Community College; working adults; and residents of Pohai Nani Good Samaritan Kauhale, a retirement community.[23]

Measurement of Euthanasia Attitudinal Variables

Euthanasia is often discussed in terms of the degree of active or passive involvement. The purpose of this study was to measure the overall reaction of respondents to the term itself. Except for consideration of self-induced death, suicide, neither qualification nor in-depth description were employed. This study focuses on respondents' agreement with five general conditions asking whether:

1. Euthanasia (mercy killing) should legalized.
2. Helping a terminally-ill loved one commit suicide is wrong.
3. Doctors should be allowed to end the life of a terminally ill patient upon request by the patient and his or her family.
4. A patient's life may be terminated if a court-appointed board determines the patient cannot be cured.
5. Euthanasia is wrong.

Independent Variables

Thirty variables were selected for this cross-sectional study of euthanasia of which 12 were structural and behavioral and 18 were attitude related. Structural variables included age, gender, place of

birth, number of years lived in Hawaii, ethnicity, education, occupation, and income. Behavioral variables were: mental outlook on life; political association; frequency of voting; religious affiliation; and, frequency of religious involvement.

Analysis

Response distributions were compared between groups utilizing the chi-square. In addition, mean scores were then compared between groups using Analysis of Variance. Each subject was given a score, coded from 0 to 4, with 0 being the most negative and 4 being the most positive. The Statistical Analysis System [SAS] program was used for statistical analysis.

Results

Condition 1 [overall probability of <0.01 to 0.57]. Legalization of euthanasia was favored by 56.2% of the entire sample of 185 individuals. 17.8% were opposed and 23.2% remained neutral. As noted throughout the study, receptiveness to euthanasia by high school students was notably low. Only 24% supported legalization, 42% remained neutral and 32% were negative to the idea.

Condition 2 [overall probability of <0.01 to 0.74]. This question drew a more positive response, asking if helping a terminally-ill loved one to commit suicide is acceptable. Of the total sample, 64.3% favored this proposal, 16.2% found it unacceptable, and slightly more (18.4%) remained neutral to the issue. Measurement of the 47 college students reaction to the subject of such mercy killing was slightly less positive: 57.9% were pro-euthanasia; 19.6% were anti-euthanasia; and 24.4% were neutral.

High school students were also more positive in answering this question, but were nevertheless half as supportive as retirees. High school students responded with 38.8% in favor, 43.1% remaining neutral, and only 17.6% in opposition. In contrast, retirees, supported the question by 71.8%, with 23.1% in opposition and 5.1% being neutral.

Condition 3 [overall probability of <0.01 to 0.70]. Overwhelming support was given the permissibility of doctors ending the life of a terminally-ill patient upon request by the patient and his or her family. 80.5% of the total sample were pro-euthanasia, 10.8% stated their opposition and only 5.4% of the respondents were neutral. The strongest support came from working adults, with a response of 91.5% positive, and 6.4% negative. It is interesting that none of this subgroup remained neutral on this question. While overall positive in their response, high school students were again notably less positive (60.7%) than other age groups in this study.

Condition 4 [overall probability of <0.01 to 0.68]. Asking whether a patient's life may be terminated if a court-appointed board determines the patient cannot be cured, this issue drew the least support with only 37.7% of the sample responding favorably. The greatest sanction came from retirees (60.5% in favor, 26.3% opposed, 13.1% neutral). High school students were again markedly less enthusiastic (28.4% positive, 35.2% neutral, 35.3% negative). College students were even less supportive than high school students (17.1% in favor, 55.4% in opposition and 27.7% neutrally positioned). Working adults straddled the middle, with 44.7% favoring the question, 38.3% being opposed and 17% remaining neutral.

Condition 5 [overall probability of <0.01 to 0.67]. Addressing the overall acceptability of euthanasia, this condition received the greatest support from working adults (76.6% in favor, 14.9% opposed and only 8.5% neutral). A higher percentage of high school students remained neutral on the issue, with 32.6% favoring euthanasia and 24.5% being opposed. This compares with an overall approval rating of 66.7% by the other three subgroups and only 16.3% opposing the concept.

Summary

Retirees were the only subgroup consistently supportive of all conditions, including the least-favored Condition 4. The mean of their positive response to the five conditions was 70%. Only Condition 3, permitting physicians to terminate life, upon request by patient and family, drew positive support from high school students (60.7%).

The most pro-euthanasia age group were working age adults, 23 to 29 years old. Their overall agreement was 78.5% The least supportive respondents were under the age of 18. This subgroup's overall agreement with the issue of mercy killing was only 37.2%. With 46.7% support, young adults 18 to 22 years old were also less than positive about the subject.

In considering the variable of education, the most pro-euthanasia persons had attained a doctoral degree or its equivalent. None of this educational subgroup remained neutral on the issue of euthanasia. Their overall agreement with the concept of euthanasia was 80%. The remaining 20% were consistently negative in their overall response.

As the statistical analysis revealed in the mean scores, none of the five attitudinal conditions drew a level of significance. However, examination of percentages indicates that younger and less educated respondents tended to be less receptive to a pro-euthanasia stance as measured through each of the five conditions.

Discussion

The purpose of this research paper was to identify those variables most closely related to attitudes toward euthanasia in Windward Oahu. Structural, behavioral and attitudinal variables were chosen and cross-tabulated to see whether age and education were factors affecting euthanasia attitudes.

Comparison of the makeup of the total sample of this survey and that of the citizenry of the State of Hawaii demonstrates a degree of likeness. At the time this sample was taken, the median age was 31.9 years with the ratio between males and females roughly 1 to 1 (with 50.9% males and 49.1% females). The racial makeup of Hawaii was: Asian, 46.6%; Caucasian, 34.4%; and Polynesian, 13.9%. The State's religious affiliation includes: Catholicism, 65.1%; Mormonism, 13.3%; traditional Protestantism, 10.7%; fundamental Protestantism, 7.9%; and Buddhism, 3.1%. Unfortunately, measurement of political affiliation was not provided in the State's statistical analysis.[24]

The median age for participants in this study was 18 years, with a quarter of this sample being high school seniors. This sample includes a lesser proportion of males (35.2%) compared to females (59.4%). This deviation from the State's average in gender, may be explained by the inclusion of 25% retired people, who generally include a higher percentage of females. When examining the gender breakdown between proponents and opponents of euthanasia, some variation is noticeable. For while those supporting euthanasia closely parallel the overall study, (57.7% being female and 36.5% being male), respondents opposing euthanasia included 76.9% women and 23.1% men.

Like the overall ethnicity of the State of Hawaii, this study's participants are not an ethnically homogeneous group. Caucasians made up 44.9% of the sample, or roughly 10% more than the State's ethnicity. Asians were underrepresented with only 20.4%, or less than half the state average. Polynesians were strongly represented at 24.1%. The ethnicity of pro- and anti-euthanasia respondents

reflected a similar broad spectrum.

Although one might expect religiosity to be a deciding factor in determining an individual's perception of the issue (as in the Jorgenson, Neubecker survey), the present study finds no such relationship. Respondents supporting euthanasia were as dedicated in their religious devotion as those of the opposite view and represented a wide spectrum of religious affiliation. The sample included traditional Protestants (28%), Buddhists (17.8%), fundamentalist Protestants (4.9%), Mormons (3.2%), and Catholics (2.4%).

Participants with both positive and negative views of mercy killing expressed generally liberal political beliefs. Of those supporting euthanasia, 36.5% described themselves as Democrats, 23.1% as Independents and 21.2% as Republicans. Respondents opposing euthanasia included 38.4% Democrats, 37% Independents and 15.4% who were non-affiliated. It is interesting to note that there were no Republicans among opponents of euthanasia.

As demonstrated in the results section of this study, life experience, as measured through age and education, does contribute to a more accepting view of euthanasia. Looking at the frequency of distribution of demographic characteristics of proponents and opponents of euthanasia, only measurements of age and education were noteworthy.

The sample of 51 Castle High School senior English students were the least positive toward the subject, with over a third indicating an anti-euthanasia view, and even more remaining neutral. Aside from age and education, the high schoolers deviated from their counterparts in few respects. They represented similar proportions of gender, race, religiosity and political orientation. The one noteworthy aspect of this group's self description was their incomplete reporting of family income which may be reflective of the students' lack of involvement in family finances.

The second group of 47 students at Windward Community College, were primarily in their first-year of college and therefore close in age to the first group. Yet they were more accepting in their overall response to the subject of mercy killing than the high school students. Nearly two-thirds of them indicated pro-euthanasia attitudes; one-fifth were anti-euthanasia; and only a quarter stayed neutral. Reporting of income was also incomplete and again may be attributed to non-involvement with family finances.

The sample of 47 working adults, from Castle High School and the general Windward Oahu community, was the most supportive of the concept of euthanasia. Over three quarters of these people were in favor of it, while less than one-fifth were in opposition and considerably less than a tenth expressed neutrality. These working adults differed from high school and college students in two meaningful ways; they were older, and had completed higher levels of education. Unlike their younger and less educated counterparts, it is likely they had had more experience with myriad life factors, including death and dying.

Occupation may be seen as another outstanding feature separating students from working adults. Over half of the 36 high school employees were teachers; the remainder included administrators, custodians, and teachers' assistants. The 11 assorted adults participating in the survey represented a broader occupational range. This subgroup included workers from business, construction, government and food service.

The fourth category of respondents consisted of 40 residents of Pohai Nani Good Samaritan Kauhale. This evangelical Lutheran retirement center is part of a chain of 200 facilities around the United States. This particular sample consisted almost entirely of Caucasians, many having come as adults from the continental United States. This disproportionate ethnic representation may in part be explained by differences in family living between white and non-white cultures. For while the nuclear family arrangement predominates among whites in the United States, the extended family, has been more traditional among non-whites.[25]

Conclusion

During the last three decades, considerable progress has been made in bringing the subject of euthanasia to the fore of public awareness. In the 1960's Kubler-Ross brought attention to death and dying. The 1970's saw an open interest in the subject of euthanasia. With today's so-called "graying of America," it is even more appropriate to look at many aspects of life for the aged and infirm, if the quality of life is to be enhanced for the nation's aging populace.

Suffering, coupled with complex medical, moral and legal issues, is clearly perceived as a poignant social dilemma. Both private and public sectors are exploring economic and humanitarian issues in health care choices. Nearly half of the states in the U.S. permit the use of living wills. Organizations, like the Society For The Right To Die, are calling direct attention to euthanasia.

This study's findings, like others,[26] found that age and education can be key variables in exploring societal attitudes. The importance of political and religious association, race and level of income were not supported in the findings of this study. Gender was somewhat meaningful in that a higher percentage of males were supportive, rather than opposed to euthanasia. In short, the original hypothesis that age and education are determinant factors in a person's view of euthanasia was born out. The greater one's life experience, as measured in increasing age and level of education, the more favorable one's attitude toward euthanasia will be.

While the health care providers contacted during this study concur in finding little change in the attitudes of staff, patients, and families since the passage of this statute, they concur that there is a clear need for legal guidelines on the issue of termination of life-supporting medical treatment.[27] As a functional democratic society attempting to meet the needs of its myriad peoples, one must move beyond analysis in academia and the media. With the passage of laws providing for living wills and durable powers of attorney for healthcare decisions, Hawaii is reaching toward resolution of this area of social, medical and legal consideration.

But many socio-economic, legal, and medical questions will have to be answered before passive, let alone active, euthanasia can become an acceptable practice. As Dr Stephen Wallach observed, everyone is learning about this issue. In their desire to fulfill patient requests, courts must consider many complexities:

1) the extent of impairment of the patient's mental faculties;
2) whether the patient is in the custody of a State institution;
3) the prognosis without the proposed treatment;
4) the complexity, risk and novelty of the proposed treatment;
5) its possible side effects [sic];
6) the patient's level of understanding and probable reaction;
7) the urgency of decision;
8) the consent of the patient, spouse, or guardian;
9) the good faith of those who participate in the decision;
10) the clarity of professional opinion as to what is good medical practice;
11) the interests of third persons;
12) the administrative requirements of any institution involved.[28]

As the United States stands on the threshold of health care reform, the issue of euthanasia is all the more relevant. What level of care

Table 1.—Combined responses of total sample of 185 persons, in 9 age groups, to combined euthanasia conditions (expressed in overall acceptability of euthanasia, measured from positive to negative).

Age Group	Most Positive	Positive	Neutral	Less Positive	Negative	Mean Score
<18	18.4%	18.8%	34.9%	9.4%	17.3%	2.1
18-22	17.8%	28.9%	32.6%	9.6%	11.1%	2.3
23-29	52.3%	26.2%	4.6%	7.7%	9.2%	3.0
30-39	45.9%	28.2%	10.6%	9.4%	5.9%	3.0
40-49	46.1%	27.8%	9.6%	9.6%	7.0%	2.9
50-59	35.0%	30.0%	1.7%	21.7%	8.3%	2.6%
60-69	37.1%	37.1%	8.6%	17.1%	0%	2.9
70-79	43.1%	29.2%	7.7%	6.2%	10.8%	2.9
80>	42.9%	23.8%	7.6%	7.6%	9.5%	2.9
Probability					0.35	0.92

Table 2.—Combined responses of total sample of 185 persons, in 8 age groups, to combined euthanasia conditions (expressed in overall acceptability of euthanasia, measure from positive to negative).

Education	Most Positive	Positive	Neutral	Less Positive	Negative	Mean Score
K-11	19.6%	19.3%	33.0%	9.6%	17.4%	2.1
High School or GED	40.0%	22.9%	19.0%	12.4%	5.7%	2.8
Technical School	55.0%	10.0%	5.0%	15.0%	15.0%	2.8
Some College	33.7%	26.8%	20.5%	9.3%	9.8%	2.6
2 years of College	32.3%	23.5%	10.8%	7.7%	4.6%	2.9
4 years of College	36.3%	40.8%	7.4%	10.4%	3.7%	3.0
Master's Degree	44.0%	23.0%	3.0%	11.0%	13.0%	2.8
PhD. or Equivalent	75.0%	5.0%	0%	5.0%	10.0%	3.4
Probability					0.40	0.95

is appropriate to the various social classes? Who will have access to transplants and other life-sustaining medical technologies?[29] The rich, the middle class, the poor? How long will patients be maintained on costly life support systems? At what point should a patient, their family and or health care provider be permitted to terminate costly medical care? Who will determine the fate of those who are not to receive continued care? Will passive, if not active, euthanasia become a wholly-accepted option in health care in America? Further study of this social dilemma will need to be undertaken before American society reaches a level of consensus sufficient to develop definitive public policies and guidelines.

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