Relationship Between Attitude Towards Euthanasia and Perceived Social Support

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Abstract

The purpose of the research was to examine the relationship between attitudes toward euthanasia and perceived social support. The study also identified gender differences and their attitude towards social support. It was a cross-sectional correlation research. The sample size was 200, and the data was collected from a general population of male and female university students through a questionnaire of Attitudes Towards Euthanasia-ATE and Perceived Social Support-PSS along with an informed consent form and a demographic sheet. The study significantly highlighted a negative correlation between ATE and PSS. It predicted that social support would be stronger, and people would receive it from family members to maintain their lives instead of terminating it. Social support was a primary source to help the patients mitigate their attitude towards euthanasia. Due to gender differences, the women received less social support, and the score on the scale of attitude toward euthanasia differs among men and women. Society, parents, family, and other peer members should be supportive to help the patient maintain their life and daily functioning.

Keywords: Gender, Attitude, Perceived Social Support**,** Euthanasia.

Introduction

Euthanasia, the intentional ending of a life to stop suffering, frequently raises concerns about a person's right to autonomy, dignity, and death. Euthanasia is regarded as a compassionate means to end suffering and a good death. The purpose is to alleviate pain and reduce symptoms related to a shortened life expectancy by attempting to prevent unwanted and prolonged suffering. Euthanasia is the Greek term "EU," which means "good," and Thanatos, which means "death," is the source of the concept of euthanasia (Ambreen et al., 2023). Euthanasia is a Greek word that means "a good death." A proper definition of euthanasia is considered as "to bring out of a gentle and easeful death to the person suffering from an incurable and painful disease or an irreversible coma" (Pearsall & Trumble, 1996). *Euthanasia* is a practice that includes several dimensions such as active euthanasia is the deliberate use of lethal injections to end the patient's life. Passive euthanasia is the intentional withdrawal of all treatments and medications in order to cause death (Rachel, 1975). Voluntary euthanasia occurs when a patient requests Euthanasia with full awareness and understanding that he or she will end his/her life (Gillon, 1988). *Involuntary euthanasia* is defined as killing a patient without his or her consent or awareness (Sugarman, 1986).

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The significance of euthanasia has changed over time. It was once seen to be a means of eliminating those who were living less honorably. Euthanasia assisted suicide occurs when a patient administers a fatal substance to terminate his or her own life in a hospital with a trained physician. However, the client is in an autonomous manner and free from any fatalistic impulses associated with mental illness. Euthanasia is a request for death in order to free the self from suffering, but the people who must make end-of-life decisions frequently depend on the availability and presence of supportive networks. Social support includes the different kinds of help and consolation people get from their social networks, such as practical, emotional, and informational support. Such assistance can be given by friends, family, medical experts, religious institutions, and support organizations. An individual's decision-making process about euthanasia and their entire experience throughout the end-of-life journey can be greatly influenced by the existence or lack of social support.

It has been demonstrated that receiving enough social support can improve a terminally ill patient's psychological health, lessen feelings of isolation and loneliness, and generally improve their quality of life. On the contrary, insufficient social support can intensify emotions of hopelessness, despair, and a desire for a speedy demise, hence raising the possibility of contemplating euthanasia as a viable alternative. The majority of patients are willing to undergo euthanasia in order to end their suffering (Khol & Kurtz, 1975). Euthanasia is a global practice. In the Netherlands, euthanasia is described as a death brought on by medication that a doctor gives with the express purpose of hastening the patient's death at the patient's explicit request; in physician-assisted suicide, the patient takes medication that a doctor has prescribed for himself or herself. In the primary 1990s, the practices of euthanasia and physician assistance in suicide were accountable to authorized examination in the Netherlands (Quill & Battin, 2004). The Netherlands is the first nation where extensive research has shed light on the practices of assisted suicide and euthanasia use in end-of-life decision-making. Euthanasia has become more commonplace throughout the world, including in several US states and parts of India.

The Dying with Dignity Bill of 2020 in Ireland sought to legalize assisted suicide and euthanasia. Diverse nations employ distinct words, and occasionally, identical terms possess distinct associations. In the United States, physician-prescribed premature death or assisted suicide is referred to as legally assisted dying. By recommending the drug that results in death, the doctor has an indirect role, even though the patient administers the drug on their own. Euthanasia and assisted suicide are included under the umbrella title Medical Assistance in Dying (MAiD) in Canada. In Australia, assisted suicide and euthanasia are both referred to as voluntary assisted dying or VAD. However, Islamic countries such as Pakistan are still opposed to the idea. In a research accompanied by Hassan et al. in a survey conducted in Pakistan to ascertain medical students' knowledge and attitudes regarding euthanasia, it was found that 58% of students opposed passing legislation allowing the practice. Only 27% agreed (Emanuel et al., 1996).

Providing care for a patient who is dying is one of the hardest clinical duties for a doctor. Doctors are educated to prolong life and go to considerable lengths to relieve suffering, particularly when maintaining an acceptable quality of life (Van der Maas et al, 1991). Therefore, social support plays an important role in each step a person takes; family and society help him face difficulties. Strong social support diminishes the negative feelings of terminally ill patients. The involvement of parents, family members, friends, and community members in times of need or crisis empowers people to improve their quality of life (Heaney & Israel, 2008; Glanz et al., 2008). The "health-related quality of life" (HRQoL) describes an individual's perceived level of physical, mental, and social welfare as well as how well they perform in their daily lives (Centers for Disease Control and Prevention, 2020)**.**

There are several reasons that motivate the individual to make end-of-life (EOL) medical decisions, including the freedom of the patient's grief and enhancing the quality of life for terminally ill patient and their families. Wide-ranging legal, medical, and ethical harmony exists about EOL care, but myths and delusions still concern what is measured as ethically and legally acceptable. Euthanasia is therefore practiced globally, in the U.S., Canada, India, and Islamic countries like Pakistan.

Literature Review

Euthanasia was common in ancient Greece and Rome. It increased and expedited the person's awareness of death. The majority of philosophers, including Hippocrates, Plato, and Socrates, opposed the idea of assisted suicide and embraced the act of dying (Papadimitriou & Skiadas, 1926). The practice of active euthanasia was prohibited in Hong Kong, but it was more prevalent in the US and Europe. Eliminating life-sustaining treatment stages was a common procedure in many industrialized and technologically advanced cultures, including Hong Kong (Anderson & Caddell, 1993; Baume et al., 1995; Wesley, 1996); seven Australian patients received authorized assistance in dying, and forty-three Oregon PAS cases were reported.

Additionally, the researcher administered opinions and behaviors surrounding the euthanasia of individuals with HIV, cancer, and immunological deficiencies. Patients with cancer are involved in about 70% of euthanasia. Another case study with a cancer patient revealed that 3200 individuals in the Netherlands participated in euthanasia annually. Other circumstances, such as hopelessness and sadness, might also influence the patient's interest in dying. In the last forty years, euthanasia has been documented in numerous nations; in certain of those, they have even received legal approval. A euthanasia act was passed in 2001 and went into conclusion in 2002. In Pakistan, 15.4% of people wanted euthanasia, with 10% of those people being students. Medical students typically deal with difficult life situations. In a survey of 100 medical students, 21% of the males and 79% of the females supported euthanasia. Because of Pakistan's low resources, 7.7% of doctors favored euthanasia (Shaikh & Kamal, 2011). The global euthanasia debate is still going strong, and nurses' perspectives are more significant. According to the Belgian Euthanasia Act (Euthanasia Act, 1), "the doctor must talk to the nursing staff if a patient makes a request for euthanasia and they regularly communicate with each other" (Van der Heide et al., 2003). Belgium had the greatest percentage (57%) of nursing staff consultations by physicians regarding end-of-life decisions, demonstrating nurses' critical role in healthcare. However, empirical research indicated that nurses participated in euthanasia on a global scale, little is known about the clinical and ethical realities behind nurses' attitudes regarding the practice (Schwarz, 1999).

Social assistance is a resource acquired through social contacts, including affection, information/advice, emotional support, and practical help (Uchino, 2004). Palliative care attempts to help patients lead as active a life as possible (World Health Organization, 2002) and enhance the quality of life for patients and their families with life-limiting illnesses (Hui et al., 2013).

A report by (Goodwin et al., 2003; Douglas et al., 2003) provided data on intervention costs and emphasized the difficulties in establishing precise cost estimates for multidimensional interventions like daycare. Daycare significantly impacted optimism and suffering (Goodwin et al., 2003; Leppert et al., 2014; Higginson et al., 2010).

There are studies conducted on gender differences in the practice of euthanasia and social support. Therapy for the female patient who wants physician-assisted suicide and euthanasia in order to relieve the stress on the family (Wolf, 1996). Social support is the positive upshot of mental health (Holt-Lunstad et al., 2010). Several strategies are available to promote mental and physical health and interaction among people (Dunton et al., 2007). Euthanasia is legally documented in some countries like the Netherlands (2001), Belgium (2002), and Luxembourg (2009), Canada (2016), which have allowed some medical conditions to help people perform (Inbadas et al., 2017). In the above countries' euthanasia is legally practiced. The procedure of informed consent and proficient request are involved prior to the euthanasia practice.

The United Kingdom has evolved from a monolithic religious and cultural state. There is a growing population diversity in cities like Glasgow, Leeds, Manchester, Birmingham, London, and Birmingham. Medical professionals face problems when providing culturally competent end-of-life care, especially in locations where there is a high number of members of ethnic or religious minorities. Hospice therapy and care for the dying have become more medicalized, and legislators, ethical scholars, the press, and physicians are interested in this topic. Of the 500,000 deaths in the UK, a sizable portion (47%) took place in hospitals. In response to clients approaching the final stage of their lives, the UK administration has said unequivocally that everyone should have access to individualized care that considers their choices, convictions, and religious desires.

There were some laws required for euthanasia in different countries. In Belgium, Luxembourg, and the Netherlands, euthanasia is legally permitted, but, in this case, the practice should be voluntary; patients must make a decision; the patient must be suffering from unbearable pain with no hope for recovery. The laws vary from country to country. In Luxembourg, the patients are terminally ill, which lasts for almost six months. The Belgium laws state that due to medical futility, in the Netherlands, the patients must be more than 12 years old, but in Belgium and Luxembourg, the patients should be above 18, and then the practice of euthanasia is supported. In Albania in 1990, the practice of euthanasia was legally accepted. According to the laws, while patients suffering from the last stage of the illness, voluntary euthanasia is permitted. In passive euthanasia, more than three family members should agree with the decision.

In Switzerland, physicians and doctors are allowed to provide an overdose of medicine to patients. Non-profit organizations manipulated the medical assistance of dying in Switzerland. In June 2016, the government of Canada passed a law to permit Canadians to request medical assistance for death, whether that will be directly injecting an alcoholic substance or prescribing drugs to patients to take by themselves wants death. In Canada, those aged 18 are mentally well but physically suffering from incurable diseases. The patient's consent should be obtained, and the patient should be ready voluntarily. There should be no external pressure (parents, society, public members) to demand death.

A study was conducted in 1990 in the Netherlands in which the effects of medicine on dying were reported among family members. The family members perceived active euthanasia positively rather than feeling sad and happy that the sufferings are skipped out. Besides this, in the general population, euthanasia was practiced, but younger adults took it very positively. A survey of medical students showed negative attitudes towards euthanasia, but their attitudes were to some extent positive in comparison to physicians because the physicians also showed fewer positive attitudes. After several studies, medical students' attitudes were comparatively examined; they showed less interest in euthanasia.

Most of the terminally ill patients expressed their feelings of dying and showed positive attitudes toward euthanasia, especially the cancer patients. In Sweden, the cancer patients committed suicide. Most of the studies on terminally ill patients and their level of intensity of pain, level of depression, level of burden, and personality type were directed to highlight the level of social and family; physicians support how they are connected to the patients in extreme pain and suffering. According to his statements, Branthwaite wrote about UK physicians,

> *The physicians should be available to help the patients at each stage of the disease but never let him move towards last stage. The individual's autonomy is important in making decisions regarding life and death, it also involves individual's perception of moral relationship such as family and friends and personal responsibilities.*

Family members are the great supporters of older adults; they receive psychological, physical, and social support from family members; therefore, family is considered the primary agency of youth and elderly (Shanas, 1979, p.5).

Study Rationale

The purpose of the research was to find out the relationship between euthanasia and social support. It was aimed at examining the thoughts of different gender and age group participants on the practice of euthanasia. The people suffering from terminal illnesses, family, parents, and others support their financial burden in order to motivate them to maintain their lives and daily routine activities. Social support is very important for terminally ill patients and others suffering from societal burdens. In Pakistan, the practice of euthanasia on cancer patients revealed that they disapproved of the practice of euthanasia because it is unethical. There are some critical conditions of the people with whom the practice of euthanasia is applied; the patients suffering from terminal illnesses such as HIV-AIDs voluntarily request an easeful death in order to relieve severe levels of suffering and pain. The practice of euthanasia in some countries is considered to be legalized, and in a few societies, it is unfollowed. Most of the time, the patients are helped by society, family, and parents in order to survive, but the supporters finally feel fatigued, and therefore, they wish to provide them with a painless death.

Study Objectives

Following are the objectives of perceived social support and attitude towards euthanasia.

- To identify the relationship between euthanasia on social support.
- To compare the attitude of male and female university students of Quetta towards euthanasia.
- To assess the differences in attitude of euthanasia from different age groups.

Methodology

Research Design

The research was completed through a cross-sectional correlational research design. This research design allowed data collection at a specific point in time, providing the picture of how euthanasia and social support are correlated. The study also assessed differences among gender and age groups on attitudes toward euthanasia. The convenient sampling technique was used with 200 sample sizes, including male (n=100) and female (n=100) samples from the University of Balochistan, Quetta science and arts departments.

Research Tools

Two scales, "attitudes towards euthanasia" and "perceived social support," along with informed consent forms and demographics sheets, were used.

Attitude Towards Euthanasia Scale (ATE)

To measure the level of euthanasia ATE, the attitude towards euthanasia (Wasserman et al., 2005) scale was used. The scale was translated into Urdu version. This scale consisted of 10 items. The items were scored on a 05-point Likert scale, including 01 as strongly disagree and 05 as strongly agree. No reversed scored items were presented. The maximum possible score was 50, which represented a favorable attitude toward euthanasia, and the minimum possible score was 10, which represented an unfavorable attitude toward euthanasia.

Perceived Social Support (PSS)

The scale was used to measure the level of social support PSS, the perceived social support (Zimet et al., 1988). This was comprised of 12 items. The items were scored on a 7-option Likert-type scale, including 01 as strongly disagree and 07 as strongly agree. No reversed scored items were present. The maximum possible score was 84, representing a high level of social support, whereas the minimum possible score was 12, a, representing a low level of social support.

Participants and Data Collection

The data was collected from 200 university participants from different science and art departments in Balochistan, Quetta. The students were approached at their department. The researcher first handed over the consent form; after obtaining the consent of the students, the students voluntarily filled out the demographics sheet and questionnaire one by one. The respondent's answers were put in the SPSS (version-23) data sheet to analyze the result. Descriptive statistics were used to abridge the demographic features of the respondents and their perception regarding the relationship between euthanasia and social support. Inferential statistics, such as Pearson Product Movement Correlation (PPMC), a correlational analysis, examined the relationship between euthanasia and social support. The results were organized and interpreted by using SPSS. Ethical considerations were monitored during the study, encompassing obtaining informed consent from participants and ensuring their responses' anonymity, privacy, and confidentiality. The research findings provided an insight that social support is higher in patients suffering from terminal illness.

Result of the Study

The study aimed to examine the relationship between social support and attitude towards euthanasia. The information was analyzed using Statistical Package for Social Sciences (version 23) to achieve the research objectives. Different analyses were applied to obtain research findings, including correlation, t-test, Alpha Reliability, and ANOVA.

Table 1: Score distribution of ATE and PSS (N=200)

Ser no	Scale	No. of items	*M*	*SD*	Range		Skew	
					Max	Min	statistics	Std. error
1	ATE	10	21.32	5.604	38	10	.307	.172
2	PSS	12	66.78	10.961	84	40	-.707	.172

Note. ATE=Attitude Towards Euthanasia; PSS=Perceived Social Support

The result explores that there are differences in mean and standard deviation on the score of participants towards PSS and ATE. The mean and standard deviation of PSS is higher than the Mean and standard deviation of ATE.

Table 2: Differences in mean and standard deviation of men and women

S. No	Scale	No of items	Men (*n*=100)		women (*n*=100)		*t*	*P*	CI 95%		Cohen's *d*
			M	*SD*	*M*	*SD*			*LL*	*UL*	
1	ATE	10	21.8	5.732	20.7	5.45	1.34	.182	-.500	2.62	0.18
2	PSS	12	66.7	11.34	66.7	10.6	.013	.990	-3.04	3.08	0.00

Note. ATE= Attitude Towards Euthanasia; PSS= perceived Social Support scale

The table shows the differences in mean and standard deviation of men and women on the score of attitude towards euthanasia-ATE and perceived social support-PSS (N=200)**.** The result indicates that there are differences in mean and standard deviation on the score of ATE and PSS among men and women. The mean difference between men and women is considered as non-significant.

Table 3: Correlation coefficient for the participants score on PSS and ATE (N=200)

Sr. No	Predictor	No of items	ATE	
			R	*P*
1	PSS	12	-.129	.068

Note. ATE=Attitude Towards Euthanasia; PSS= Perceived Social Support scale

The result indicates that though both variables have non-significant correlation but the direction of correlation coefficient indicates that with increase in perceived social support, the attitude towards euthanasia may become negative.

Table 4: **Differences in mean and standard deviation on the scores of participants in three age groups on PSS and ATE (N=200)**

Sr. No	Scale	No of items	Age Group	*N*	*M*	*SD*	*F*	*p*
1	ATE	10	18-20	36	22.33	5.752	.896	.410
			21-23	129	20.96	5.496		
			24-26	35	21.60	5.862		
2	PSS	12	18-20	36	66.86	11.630	.168	.846
			21-23	129	66.50	10.807		
			24-26	35	67.71	11.095		

Note. ATE=Attitude Towards Euthanasia; PSS=Perceived Social Support scale

The result indicates that there are mean differences among three different age groups. Considering the ATE and PSS mean differences were found to be non-significant.

Table 5: Reliability coefficient for score of participants on PSS and ATE (N=200)

Sr. No	Variables/scale	No. of items	Cronbach's Alpha
1	PSS	12	.797
2	ATE	10	.604

Note. ATE=Attitude Towards Euthanasia; PSS=Perceived Social Support

The result considers that the Cronbach's Alpha reliability on the score of PSS is quite good and examining the Cronbach's Alpha reliability on the score of ATE is satisfactory.

Discussions

The purpose of the study was to identify the relationship between attitudes toward euthanasia and perceived social support. It also examined the differences between genders and different age groups in the practice of euthanasia. Women were highly victims of depression and anxiety and received less social support (Rosenfield, 1989). Accordingly, the current result of the study, the mean score of women and men on perceived social support was relatively equal (66.7), and the attitude towards euthanasia in men was higher than in women. The mean score of men is (21.85) while the mean score of women is (20.79) on the score of attitudes towards euthanasia. The alpha reliability showed (.80 for *PSS* and .60 *ATE*) and the (*PPMC* -.12) because of a negative relationship between *PSS and ATE*. Family members highly supported the people suffering from terminal illnesses. Two hundred participants were taken through convenient sampling; they consented to participate in the research study. The sample was divided into two groups of University of Balochistan students, including the Arts and Science departments. The sample was further divided into two gender groups and three age groups. After examining the results of the current study indicated that social support towards patients suffering from physical or psychological disturbance, financial burden, or other social issues was a great source to maintain their lives and change their attitude regarding the termination of life. People suffering from severe levels of depression also demand assisted death, but social support plays an important role in the reduction of the level of depression. The individual interacted with family members, and the support they obtained from their surroundings and family alleviated their negative feelings. Social support lessens mortality (Aksullu, 2004; Tan & Karabulut, 2005).

There are gender differences in physical or psychological symptoms (Rosenfield, 1989). Theoretically, it was stated that the acceptance and respect of an individual from society boost their self-esteem, confidence, and coping skills towards depression. A model was presented by Windle (1992), which represents that social support reduces the level of stress and depression. In 1992, the World Health Organization (WHO) diagnosed some psychotic disorders, such as schizophrenia, bipolar disorder, and severe depression patients. The purpose was to provide them with medical or psychiatric care who were fed up with their lives. Different studies were conducted on perceived social support to mitigate the level of disease. The connection with family, peers, and others is a source to provide mental and physical relief. Society, family, and friends support decrease the number of patients suffering from terminal illnesses. The World Health Organization (2015) developed that each country should be responsible for the development of Health care centers in order to assist the victim to maintain their normal life. According to WHO, "universal access to health services without any financial hardship." Social protection strategies and social support networks should be available during illness events.

The social support lessens the mortality rate. Patient with cardiovascular disease, cancer, and AIDS take a positive and hopeful step toward recovery of life while their society serves them with an extreme level of support. A cross-sectional study was conducted on the relationship between the working environment of people and the physical and psychological illness of the individuals. The research was piloted on mortality issues (Berkman & Syme, 1979; House et al., 1982; Schoenbach et al., 1986), which were caused by smoking cigarettes, high blood pressure, cancer, and other psychological problems. The mortality rate was reduced due to the assistance and care of family and other members of society. People suffering from low socio-economic status and financial burden want to escape life's sufferings, so family and social welfare provide them with basic instruments to spend their lives satisfactorily (House et al., 1982). The role of social support is to identify the severity and onset of the disease and work for its recovery.

Anyhow, after examining the result of the current study, it indicated that social support towards patients suffering from physical or psychological disturbance, financial burden, or other societal issues was a great source to maintain their lives and change their attitude regarding the termination of life. The correlation coefficient analysis was applied in this current research study. The result articulated that the correlation coefficient between Perceived Social Support-PSS and Attitude towards euthanasia-ATE is negative.

Conclusion

The purpose of the study was to examine the relationship between euthanasia and social support. Euthanasia is the practice of terminating a life, so society and family members should be supportive of people and diminish the practice of euthanasia. There were differences in gender and age level in the practice of euthanasia. The findings of the study showed that there were several factors affecting the demand for euthanasia, such as extreme levels of suffering from illness, financial burden, and other epidemic diseases. Some practices were lawful in the country, and some people voluntarily acted towards these practices. Therefore, society should be supportive and provide fundamental facilities to lessen these severe effects. Not only the men were affected, but also women were involved in the practice of euthanasia. A supportive society mitigates the rate of mortality. Low socio-economic status, financial burden, and deprivation from resources increase the mortality rate and obligate the individual to end their life. Our results showed that a person's social support network was not related to a strong predictor of their stance regarding euthanasia. The present study on euthanasia in this region of the globe can be quite helpful in acquiring a basic understanding and kicking off serious conversations regarding the practice. Hence, there should be more findings available on the relationship between euthanasia and social support so that more awareness should prevail.

Recommendations

Based on the above-mentioned important findings, certain recommendations can be taken into account:

Firstly, enhancing palliative care services can help people who are suffering from life-limiting illnesses feel healthier and relieved from their pain.

Secondly, a comprehensive social support network that includes therapists, counselors, psychologists, and support groups that focus on end-of-life care should be developed. People thinking of ending their lives could get practical, emotional, and psychological help from these networks. Beyond providing medical care, social support should be expanded to meet people's general needs. The patient's doctors, family, and other medical professionals must show their support and assistance.

Thirdly, legal and ethical frameworks should be strengthened to protect patients against the practice of euthanasia. These frameworks must guarantee that informed consent is the foundation for the decision-making process.

Lastly, strategies intended to lessen the financial burden and emotional stress associated with making medical decisions in the final stages of life must be implemented for patients and their families.

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