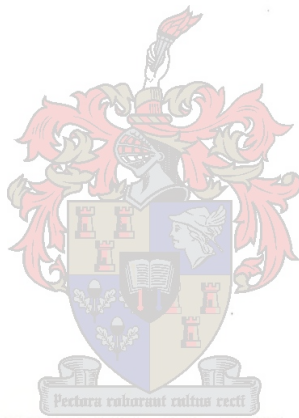


OLDER ADULTS' VIEWS ON EUTHANASIA

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.

Signature

Date

ABSTRACT

The purpose of this study was to determine the attitudes older adults (65 years and older) have towards euthanasia. The subjects of the study were people 65 years of age and older who reside in homes for the aged within the Cape Metropolis. An equal number of subjects from the African, Coloured and European communities were randomly selected. A biographical questionnaire as well as the Euthanasia Attitude Scale and the Purpose In Life Test, were administered. The influence of four variables were focused on, namely age, ethnicity, meaning in life and health. Pearson correlation coefficient analysis and one-way ANOVA analysis were used. Ethnicity, meaning in life and health were not found to have a significant correlation with euthanasia. Age was the only variable found to have a significant correlation with euthanasia. The findings were discussed and certain recommendations were made.

OPSOMMING

Die doel van die studie was om vas te stel wat die houding van ouer volwassenes (65 jaar en ouer) is ten opsigte van genadedood. Die proefpersone was almal ouer as 65 jaar en woonagtig in ouetehuse binne die Kaapse Metropol. 'n Gelyke aantal proefpersone van die Afrika, Kleurling en Europese gemeenskappe is willekeurig gekies. 'n Biografiese vraelys, asook die "Euthanasia Attitude Scale" en "Purpose In Life Test", is gebruik. Die invloed van vier veranderlikes, naamlik: ouderdom, kultuur, betekenis in die lewe en gesondheid, is ondersoek. Pearson korrelasionele koëffisiënt en een-rigting ANOVA ontledings is gebruik. Etnisiteit, betekenis in die lewe en gesondheid het nie beduidend met genadedood gekorreleer nie, ouderdom was die enigste veranderlike wat beduidend met genadedood gekorreleer het. Die bevindinge is bespreek en sekere aanbevelings is gemaak.

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Table of contents

	<u>Page</u>
DECLARATION	
ABSTRACT	
OPSOMMING	
ACKNOWLEDGEMENTS	
ADDENDA	iv
LIST OF TABLES	v
1. INTRODUCTION AND AIMS OF STUDY	1
1.1 Introduction	1
1.2 Motivation	2
1.3 Aim	4
1.4 Limitations of the study	5
2. REVIEW OF LITERATURE AND THEORETICAL DISCUSSION	6
2.1 Background	6
2.2 Definition	7
2.3 A moral dilemma	9
2.4 Factors influencing attitudes towards euthanasia	9
2.4.1 Age	9
2.4.2 Ethnicity	10
(a) Profile	10
(b) Ethnicity and euthanasia	12
2.4.3 Meaning in life	13
(a) Suffering	13
(b) Existential vacuum	14
(c) Death as <i>finis</i>	15
2.4.4 Health status	16

2.5 Arguments in favour of euthanasia	18
2.5.1 Autonomy	18
2.5.2 Mercy	19
(a) Medical opinion	19
(b) Palliative care	20
(c) Doctrine of double effect	21
2.5.3 Religion	21
(a) Playing “God”	21
(b) The views of the churches	22
2.5.4 Regulation of euthanasia	22
2.6 Arguments opposing euthanasia	24
2.6.1 Sanctity of life	25
(a) Christianity	26
(i) Dutch Reformed Church	26
(ii) The Roman Catholic Church	27
(iii) African Christian Church	28
(b) Judaism	29
(c) Buddhism	29
(d) Muslim	30
(e) Hinduism	31
2.6.2 “Slippery slope” argument	31
2.6.3 Dangers of abuse	32
(a) Emotional fluctuation	32
(b) Financial burden argument	32
2.6.4 Physician’s role	34
(a) Physician’s authority	34
(b) Physician’s commitment	34
(c) Palliative care	35
(d) Experience and field of practice	37

2.7 Legal	38
2.7.1 Religious dogma	38
2.7.2 Present position	39
2.7.3 Proposed changes	39
2.7.4 Dutch model	40
2.7.5 Conclusion	41
3. METHOD OF RESEARCH	43
3.1 Formulation of research questions	43
3.2 Subjects and data collection procedures	43
3.3 Measuring instruments	46
3.3.1 Euthanasia Attitude Scale	46
3.3.2 The Purpose In Life Test	47
3.4 Statistical techniques used	48
4. RESULTS	49
5. DISCUSSION AND RECOMMENDATIONS	55
5.1 Introduction	55
5.2 Euthanasia Attitude Scale	55
5.3 Age	55
5.4 Ethnicity	56
5.5 Meaning in Life	57
5.6 Health status	58
5.7 Conclusions	59
5.8 Recommendations	60
REFERENCES	62

LIST OF TABLES

Table 1	Results of the Biographical Questionnaire (N=120)	45
Table 2	Descriptive Analysis of Euthanasia Attitude Scale and the Biographical Variables	50
Table 3	Results of a One-way ANOVA of Total Euthanasia Attitude Scale and Biographical Variables	51
Table 4	Frequency Distribution of Total Population Regarding the Euthanasia Attitude Scale (N=120)	51
Table 5	Mean differences on the Total Euthanasia Attitude Scale and Sub-scales for People Favouring and Opposing Euthanasia	52
Table 6	Mean difference on the Purpose In Life Test for People Favouring and Opposing Euthanasia	52
Table 7	Pearson Correlation Coefficient Between Euthanasia Attitude Scale, Purpose In Life Scores and Some Biographical Variables	53
Table 8	Frequency Distribution of those Favouring and Opposing Euthanasia According to Age	54

Chapter 1

INTRODUCTION, MOTIVATION AND AIM OF STUDY

1.1 Introduction

Between 1936 and 1941, the life expectancy of the average South African person was 49 years (van Rensburg, Pretorius & Fourie, 1992). Today, according to the Development Bank of South Africa (1996), this figure has risen to 70 years.

The rise in life expectancy can be attributed to great technological improvements in the medical field, better health care (such as the prevention and treatment of many childhood illnesses), and political and economic infrastructure reform which provide citizens with better medical care, necessary food and hygienic conditions (Hayflick, 1987; Seale & Addington-Hall, 1994; van der Maas, van Delden, Pijnenborg & Looman, 1991). As a direct result of these improvements, 9.6% of the South African population are now older than 65 years (Central Statistical Service, 1996).

However, social reality is such that the effect of AIDS increasingly poses ethical questions. Antenatal surveys project that the life expectancy average will fall to only 37.5 years by the year 2010 as a direct result of AIDS (Esterhuyse & Doyle, 1994; Sidiropoulos et al., 1998). The increase in AIDS deaths and the ageing population have introduced new issues into society, such as the ethics surrounding medical decisions to end life. An example of this is euthanasia, that is, an act or omission intended to shorten life, carried out by a person other than the person concerned, upon the request of the latter (Hessing, Blad & Pieterman, 1996).

Since cancer is still the biggest cause of death in South Africa (Hospice Annual Report, 1999) this study will focus only on the effect of cancer and not AIDS. It is important, however, to stress that there is an increasing need to research the relevance of euthanasia with regards to AIDS.

1.2 Motivation

It can be argued that caring for the elderly (especially those who are ill and/or physically incapacitated) not only drains already limited health care resources, but also consumes time, effort and money that could be used elsewhere. Since older people are often perceived as neither useful to others nor in control of their own lives (Kastenbaum & Schmitz-Scherzer, 1987), they frequently receive no more than last minute intervention in emergency departments. According to Schanker (1996) the availability of non-emergency care for the elderly continues to erode.

Society is increasingly dedicated to speed and efficiency and suffering is no longer viewed as an acceptable and an inevitable part of living. Consequently euthanasia is often seen as a process whereby death and suffering is made tolerable and decent (Cherney, 1996). Research done in The Netherlands shows that the incidence of euthanasia has increased considerably since 1990 (van der Maas et al., 1996). Studies conducted by van der Maas, van Delden, Pijnenborg and Looman (1991) show that 38% of all recorded deaths involved medical decisions to end life. Of these, 85% involved older, medically ill people. In view of these figures, as well as the increase in the elderly population, the emergence of improved life preserving techniques, and issues concerning personal autonomy, (Seale & Addington-Hall, 1994), it is clearly of great importance to study the attitudes of older adults (65 years and older) towards euthanasia.

Very little study has yet been done concerning the attitudes of older adults towards euthanasia, and there exists a great need for research into the influence of demographic factors on their views (Cicerelli, 1997). According to Rogers (1996), mediating factors, such as age, have a significant influence on an individual's acceptance of the right to die. Koenig (1993) also focussed on the need for research into the views of the elderly on euthanasia. In their study of the general population's view regarding euthanasia, Nance and Ruby (1996) found that most studies did not represent the attitude of the general population, but focussed on young, healthy adults. They suggested that future studies

should focus on older adults. No comparative research data relating to the older South African population exists.

Attitudes toward life and death are socio-culturally based and ethno-culturally specific (Comaz-Diaz & Griffith, 1988; Hessing et al., 1996; Lee, Kleinbach, Hu, Peng & Chen, 1996). Given the diversity of the South African population, it is therefore important to include ethnicity in the study, discussion and assessment of attitudes towards euthanasia. Studies done in the nineties (Anderson & Caddell, 1993; Hessing et al., 1996; MacDonald, 1998) support this contention.

According to Frankl (1960), the finite nature of human existence influences a person's view of life and how he or she evaluates the decisions surrounding death as either a meaningful or a fearsome eventuality. The study will therefore also focus on Frankl's philosophy regarding the influence of the realisation of the finality of death on the meaning a person finds in life.

Health status also plays an important role in the attitude a person will have towards euthanasia. According to Dare (1987), approximately 40% of all cancer patients experience severe pain at some time during their illness, while about 5% of all cancer patients suffer intolerable pain which cannot be controlled (Baines, 1984; Dare, 1987; Daut & Cleeland, 1982). When a terminally ill patient's pain reaches a certain level, consciousness becomes constricted to the point where choices other than ending his or her own life cannot be appreciated (Koenig, 1993; MacDonald, 1995). Euthanasia or physician-assisted suicide could then be seen as a means of escaping the threat of overwhelming pain, and in this way pain and pain relief are indirectly related to the suicidal ideation (Levine, 1997; MacDonald, 1995).

Presently, South Africa is facing proposed changes to the legislation on euthanasia. In the light of a request by the South African Voluntary Euthanasia Society (SAVES), the South African Law Commission (SALC)(1997) released a discussion paper (Discussion Paper 71, Project 86) suggesting changes to legislation. Their proposal favours voluntary

euthanasia, which will allow a person who is still of a clear mind and who has considered and evaluated all possible options, to ask another to end his or her life. This is opposed to the present position, which states that it is unlawful to intentionally end a person's life in order to end his or her suffering or dissatisfaction with life, even if it is at his or her request.

1.3 Aim

An overview of literature (Anderson & Caddell, 1993; Førde, Aasland & Falkum, 1997; Ganzini, Fenn, Lee, Heintz & Bloom, 1996; Koenig, 1993; Ward & Tate, 1994) has shown that a wide range of opinions exists among health care professionals concerning the issues surrounding euthanasia.

As health psychology develops, psychologists and counselling professionals are becoming progressively more involved with patients who have chronic terminal illnesses such as AIDS, Alzheimer's disease and cancer. Consequently, they will be increasingly consulted by patients, caregivers and lawyers in cases where euthanasia is being considered (Hadjistavropoulos, 1996). According to the researcher of this study, this is the main reason why psychologists need to understand the motivation and reasoning behind end-of-life decisions. By presenting the opinions of the elderly, this study will attempt to create a more informed sensitivity among health care professionals towards the attitudes of those mostly concerned with the controversies surrounding euthanasia.

Taking into account the proposed changes to legislation, the lack of national and international information regarding the views of the elderly, and the need for a greater sensitivity amongst psychologists, this research will attempt to shed light on the attitudes of the older adult population with regards to euthanasia. Variations in cultural background, purpose in life, health and the effect of age will form the basis of this study. The purpose is to establish the influence of such variables on the attitudes of older adults towards euthanasia. It will be suggested that older adults from different cultural

backgrounds, different age groups, different health statuses, and with different views about their purpose in life will have different views concerning euthanasia.

1.4 Limitations of the study

In South Africa, there are nine main indigenous African ethnic groups, namely the Ndebele, Northern Sotho, Southern Sotho, Swazi, Tsonga, Tswana, Venda, Xhosa and Zulu.

The present study was limited to the Cape Town Metropolitan area. The discussion and results relating to the African part of the sample of this study was limited to the Xhosa ethnic group since it is the largest indigenous African group in the Western Cape. The term “African people” used in this study does therefore not refer to all African ethnic groups in South Africa, but only to the Xhosa ethnic group. However, from the limited literature available, the researcher established that most African ethnic groups share similar traditional beliefs concerning life and death (Broster, 1982; Pauw, 1963; Rabe, 1993; Soga, 1964; van Rensburg, Pretorius & Fourie, 1992; Wilson, Kaplan, Maki & Walton, 1952) and it can therefore be assumed that other ethnic groups will share similar views to that found in Xhosa people in this study.

Chapter 2

REVIEW OF LITERATURE AND THEORETICAL DISCUSSION

The debate surrounding euthanasia comprises moral, legal, ethical, philosophical and medical arguments and issues. This study will therefore not focus on the literature and theoretical arguments as separate entities, but will present them as a whole.

2.1 Background

The word euthanasia has its origin in the classic, ancient writings of Greece, with “THANATOS” meaning death and the prefix “EU” meaning easy or good (Dierick, 1983; Russell, 1977; Wennberg, 1989). The early Greek and Roman civilisations held comparatively liberal attitudes towards euthanasia (Brigham & Pfeifer, 1996; Downey, 1995). Greek philosophers such as Socrates, Plato and Epictetus (Burckhardt, 1998; Russell, 1977) claimed the same freedom to die that they had in life, and voluntary death gradually became part of their system of thought. They held, for example, that no elaborate attempt should be made to keep invalids, for whom there were no hope of recovery, alive. This belief was so strong that Socrates himself escaped the horror of pain and suffering by drinking hemlock (Deutsch, 1936). The sympathy that existed for euthanasia in the ancient world was, however, largely extinguished by the teachings of the Christian church (Wennberg, 1989) and the Islamic teachings of the prophet Muhammad (Larue, 1996).

By means of the Qu’ran, Muhammad taught that there is no justification for taking one’s own life to escape suffering and that the concept of a life not worth living does not exist (Larue, 1996; Oosthuizen, 1988). In the 5th century AD, the Christian Saint Augustine (Downey, 1995; Wennberg, 1989; Russell, 1977) also contended that any form of self-killing was a violation of the sixth commandment (according to Roman Catholicism, otherwise the fifth according to Protestantism) “Thou shalt not kill”. The 13th century theologian, Saint Thomas Aquinas, reinforced this view. Saint Thomas held that to kill

oneself was to usurp God's power over creation and death. He also stressed that self-destruction is contrary to man's natural inclinations and natural law, and that man furthermore has no right to deprive society of his presence and activity (Russell, 1977).

2.2 Definition

Simply put, euthanasia refers to the implementation of a decision to commit or omit an act at the request of a particular individual, with the effect that the life and suffering of that individual comes to an end before it needs to (Angell, 1988; Harris, 1994; Nance & Ruby, 1996). However, current attitudes toward euthanasia have become much more complex and, subsequently, more confusing (Brigham & Pfeifer, 1996). This can be ascribed to a number of philosophical, medical and religious changes that have occurred during the past 150 years, and which have resulted in many different definitions of euthanasia. Although it is not the purpose of this study to justify any one definition, a general overview of the definitions of euthanasia that are found in literature will be discussed.

At the core of the euthanasia debate lies the distinction between active and passive euthanasia. This distinction is based upon the difference between acting (killing) and omitting to act (letting die). *Active or positive euthanasia* refers to a positive, merciful act taken deliberately to end futile suffering or a meaningless existence. It is an act of commission, where death is induced, either by direct action to terminate life or by indirect action, such as injecting a lethal dose of morphine or potassium chloride, which will almost certainly hasten death (Darley, Loeb & Hunter, 1996; Russell, 1977; Schanker, 1996). *Passive or negative euthanasia*, on the other hand, occurs where the use of "extraordinary" life-sustaining measures are discontinued or refrained from. No more "heroic" efforts are made in an attempt to prolong life in hopeless cases where such prolongation seems an unwarranted extension of either suffering or unconsciousness. Included in this definition is the omission of medication or other life-sustaining therapy; the refusal to perform surgery; the withholding of attempts to resuscitate when the patient's vital system fails; the withdrawal of artificially supplied nutrition and hydration.

In essence, it is to refrain from any action which would probably delay death and instead to permit natural death to occur (Darley et al., 1996; Russell, 1977; Schanker, 1996; Wennberg, 1989).

It is important to note that this distinction is not valid in South Africa as the law still regards both action and omission as unlawful in cases where a duty of care exists (SALC, 1997).

A distinction is further drawn between voluntary, involuntary and non-voluntary euthanasia. *Voluntary euthanasia* occurs when the decision to end life coincides with the individual's own wishes and he or she consciously approves of euthanasia and all aspects of its implementation. (Darley et al., 1996; Harris, 1994; Pollard & Winton, 1993; Russell, 1977). *Involuntary euthanasia* takes place where such a decision is implemented against the express wishes of the individual (Darley et al., 1996; Harris, 1994; Pollard & Winton, 1993; Russell, 1977). *Non-voluntary euthanasia* pertains to cases where persons are incapable of making their wishes known, for example where a person is in an irreversible coma or where infants are severely defective (Pollard & Winton, 1993; Russell, 1977). The terms discussed here can also be combined with the terms "active euthanasia" and "passive euthanasia", giving rise to terminology such as "involuntary passive euthanasia" and "voluntary active euthanasia".

Part of the confusion surrounding the meaning of euthanasia lies in its close relation to, yet distinctness from, physician-assisted suicide. Physician-assisted suicide occurs when a physician intentionally and wilfully acts in a way that helps a suicidal patient to end his or her life. This may involve providing information on ways to commit suicide, supplying a prescription for a lethal dose of medication, or even providing a suicide device that the patient can operate - such as the "suicide machine" invented by Jack Kevorkian (Hessing et al., 1996; Koenig, 1993; Pollard & Winton, 1993; Sagel-Grande, 1998). Despite its similarities to euthanasia, it is imperative, however, to note that euthanasia and physician-assisted suicide are different acts with different responsibilities for the physician. In the case of physician-assisted suicide the physician merely assists the patient (Latimer &

McGregor, 1994; van der Wal & Dillmann, 1994), while in the case of euthanasia, as discussed earlier, the physician acts actively or passively.

2.3 A moral dilemma

Questions about life and death will always be among the major issues society has to face collectively as a group and individually by every member of that group. The ageing population, the increase in cancer deaths and expected AIDS deaths, the development and expansion of life-prolonging technologies, the possible generational and cultural changes in the attitudes of patients, and care of the dying are fast creating grave moral dilemmas for society. These matters have created a serious need to re-examine the ethical and legal status of euthanasia and physician-assisted suicide (Chochinov & Wilson, 1995; Latimer & McGregor, 1994). Such a re-assessment would need to pay special attention to ethnic diversity (Hessing et al., 1996; Lee et al., 1996), as different belief systems and norms of behaviour (Nxumalo, 1998) will affect views surrounding euthanasia. Although culture presents the individual with norms and guidelines in which lives may find meaning (Baumeister, 1991), attitudes towards euthanasia are more complicated than simply voicing an opinion in favour of or against it. This 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 values and customs, political orientation, economic situation, medical developments and legal issues (Bachman et al., 1996; Blendon, Szalay & Knox, 1992; Cicerelli, 1997; Darley et al., 1996; Ho & Penney, 1992; Lee et al., 1996; Scott, 1998).

2.4 Factors influencing attitudes towards euthanasia

2.4.1 Age

Age has a strong impact on people's views regarding euthanasia. Rogers (1996) makes a compelling argument that the assessment of attitudes toward euthanasia must be based on a conceptual model that incorporates the age of the individual. The Harvard study (as



cited by Koenig, 1993) found that whereas 79% of 18 – 34 year olds favoured physician-assisted suicide, only 64% of 35 – 49 year olds and 53% of those over the age of 50 favoured it. Although no information was given concerning the views of persons aged 65 years or older, the downward trend among the above-mentioned three age groups indicate that the percentage of those over 65 who favoured physician-assisted suicide would possibly fall below 50%. These findings are supported by studies conducted by Bachman et al. (1996), Blendon et al. (1992) and Cicerelli (1997). Twycross (1990) showed that older people tend to disapprove of euthanasia because of the fear that their lives may be ended against their will when they are no longer in complete control of their circumstances. This is supported by Cicerelli (1997), who points out that it is significant that a large proportion of older people strive to live as long as possible, no matter how onerous life becomes. Research done by van der Maas et al. (1996) has shown that the fear of life being ended without consent is legitimate, as 23% of doctors interviewed confirmed that they have ended a patient's life without his or her explicit request. It could be argued that older persons may be less fearful of death since they realise that it is a nearing event, and they are therefore less desperate to be in complete control of the process (Koenig, 1993). The reasons why older adults may or may not elect euthanasia are, however, arguable.

2.4.2 Ethnicity

Attitudes toward life and death are socio-culturally based and culturally specific (Hessing et al., 1996; Lee et al., 1996). According to Comaz-Diaz and Griffith (1988), a person's ethno-cultural identity, that is, the collective values and norms of a specific ethnic group within a specific culture, gives him or her a unique view of life and death. It is therefore important to include ethnicity in a study that assesses attitudes towards euthanasia.

(a) Profile

The South African society is characterised by a complex array of economic, cultural, class and ideological factors, many of which are in sharp contrast and conflict with one

another (McKendrick & Hoffman, 1990). One dimension of this complexity flows from the contrast between the first and third world orders in South African society (Pauw, 1978; van Niekerk, 1996).

Until recently, under the apartheid system, the South African population was loosely defined in terms of three “racial groups”, namely African, Coloured and European. According to Rabe (1993), these “racial groups” did not necessarily represent meaningful cultural groups, especially since the classification of Africans included a wide range of different ethnic groups, such as the Tswana, Venda, Zulu, Xhosa, Ndebele and Sotho. Groenewald (1987) furthermore explains that, according to Proclamation 123 of 1967, the Coloured ethnic group includes any person who is a descendant of Cape Coloured, Malaysian, Griqua, Chinese, Indian, or other Asian immigrants or slaves. The entire social, political and legal structures of South Africa were designed around these racial categories (Rabe, 1993).

For the purpose of this study, the term “Africans” will refer to members of the Xhosa group and “Coloureds” to all people classified as Coloureds in terms of the Population Registration Act (Act 30 of 1950). According to this Act a Coloured is any person who is neither from European nor from African descent, or any person with mixed bloodlines (Groenewald, 1967).

The estimated population of the Western Cape forms 10.9% of the total South African population and is proportionally represented by 827 000 Africans (mostly Xhosa), 2 186 400 Coloureds and 822 000 Europeans (Orkin, 1999). Although ageing occurs in all three groups, Europeans have a larger share in the age class 65 years and older than the two other groups (Sadie, 1993). Even so, because of the size of the group, more than two-thirds of pensioners come from the African population (Sadie, 1993). According to the age profile for the Western Cape, 5.5% of the population is older than 65 years of age and this group has an average life expectancy of 67.8 years (Sidiropoulos et al., 1998).

(b) Ethnicity and euthanasia

Authors such as Blendon et al. (1992), Cicerelli (1997), Early and Akers (1993), MacDonald (1998), Monte (1991), Singh (1979), Ward (1980) and Zalick (1980) found that people from an African background were more opposed to euthanasia than those from an European background. MacDonald (1998) suggests that a possible explanation for this lies in the fact that members of the African ethnic groups are less likely to release power over their lives to others. Further explanations are that Africans are not self destructive because they direct their aggression outwards rather than inwards and they expect life to be harsh (Cicerelli, 1997; Rabe, 1993; Zalick, 1980). Early and Akers (1993) are of the opinion that major social factors, particularly religion and family, provide a buffer of social forces which prevent self-destruction in any form.

Within the South African context, African communities have an effective social support system and are stereotyped as “looking after their own” (Rabe, 1993). For Africans, death and dying form an integral part of their everyday existence (Pauw, 1963; Soga, 1964). According to the African belief system, the soul of the departed person passes to the world of the ancestral spirits where it continues to live on (Broster, 1982; Pauw, 1963; Pauw, 1978). However, if a person decides to end his or her own life, that person’s soul is doomed and becomes an evil spirit (Forster & Keen, 1988). In their study, Forster and Keen (1988) found that only 14,3% of the respondents - compared to 10% according to Mayekiso (1995) - believed that it would be acceptable for somebody to end his or her own life in the event of unbearable illness. The remaining 85.7% (Forster & Keen, 1988) or 90% (Mayekiso, 1995) finds it totally unacceptable, because of the view that all problems can be solved and one does not collapse in despair when difficulties occur.

According to Venter (1974), Coloured people have no tribal life and speak no native language. Groenewald (1987) explains that the reason for this is that Coloured people are the victims of acculturation – the transfer of one ethnical group’s culture to another (Plug, Meyer, Louw & Gouws, 1991). Despite the fact that they have acquired most of the

prominent norms and values of the European community (Groenewald, 1987; Rabe, 1993), the Coloured community are still characterised by high group coherence and a strong religious belief system (Rabe, 1993). There exists, however, no literature regarding the attitudes of members of the Coloured community concerning euthanasia. This adds to the importance of this study.

2.4.3 Meaning in life

Within and between all ethnic groups social relationships are very important (Groenewald, 1987; Rabe, 1993; Rautenbach, 1989). Finding meaning in life is a tool used to adapt and control the environment and social relationships, to regulate the self, and to achieve a sense of belonging (Baumeister, 1991). The lack or loss of meaning - when the world fails to make sense in some vitally important way - is often central to suffering and unhappiness. Suffering, according to the researcher of this study, stimulates the need to find meaning in life and the way in which a person perceives his or her suffering will influence his or her attitude towards life and death (Frankl, 1985). It is therefore important to include the meaning found in life in a discussion regarding euthanasia.

(a) Suffering

Suffering does not refer to a transient or fleeting experience, but to an enduring, psychological state which includes negative thoughts such as fear, hopelessness, discouragement, fatigue, anger, and feelings of entrapment (Chapman & Gavrin, 1996; Koenig, 1993). It is therefore not unusual for suffering to induce a great sense of helplessness, hopelessness, futility, meaninglessness, disappointment, remorse, disruption of personal identity and death anxiety. These feelings affect every person's quality of life and may provoke the desire for an early death in those who suffer severely (Breitbart & Passik, 1995; Cherney, 1996; Daut & Cleeland, 1982; Levin, Cleeland & Dar, 1985; Seale & Addington-Hall, 1994; Yalom, 1980).

The onset of suffering may be accompanied by loss of meaning, as suffering or trauma breaks apart the comprehensible world and thrusts a person into a painful state marked by senselessness and instability. Suffering, such as chronic pain, presents an individual with a difficult problem, namely the loss of a meaningful, predictable, orderly, understandable world. The resultant lack of meaning increases the difficulty of coping with chronic pain (Baumeister, 1991). According to the existential phenomenological philosophy of Viktor Frankl, man needs to know *what* he suffers for to find meaning in his suffering, and that it is not so important that man knows *why* he suffers.

(b) Existential vacuum

According to Frankl (1960; 1967; 1985), man has the ability to decide how to react under certain conditions, to choose his attitude in a specific situation, and to rise above his circumstances to a noological state of freedom. The noological level presents a level at which man can freely reflect upon him- or herself, make a stand against suffering and transcend the level of somatic and psychological determinants.

Transcendence, which is a uniquely human ability, occurs when man forgets his suffering and rises above himself to reach out to other human beings and to find freedom in meaning or logos (Frankl, 1967; Frankl, 1980; Frankl, 1985; Havenga, 1974; Luijpen, 1976). When this freedom and responsibility diminishes due to declining forces of religion, traditional morality and values, and man becomes a victim of conformity and totalitarianism, life becomes meaningless (Baumeister, 1991; Frankl, 1967; Frankl, 1980; Havenga, 1974) and an existential vacuum develops.

An existential vacuum results in conscious conflicts, value clashes and value gaps which deprives life of its meaning (Frankl, 1967; Frankl, 1980). Instead of offering firm answers on right and wrong, society presents man with an assortment of possible views and allows him to choose between them. Consequently, he finds it difficult to be certain that his actions are good and his life has value. This has a direct influence on his views about life and death.

(c) **Death as *finis***

According to Saunders (1992), founder of the modern Hospice, “the search for meaning” - understanding one’s own unique meaning based on one’s own unique existence (Frankl, 1967) - has frequently been put forward as a patient’s important, final aim.

Coping with and adjusting to suffering depend on finding a way of making sense of misfortune, seeing the relevance of it and finding purpose in it (Baumeister, 1991; Giorgi, 1978). However, man is threatened by his guilt over the past and his fear of future death. Both are inescapable and both must be accepted (Frankl, 1967). Thus, man is confronted with the ontological human conditions of fallibility and mortality. Properly understood, it is precisely the acceptance of this twofold human finiteness which makes life worthwhile (Frankl, 1967). Meaning is found in the realisation that only in the face of guilt does it make sense to improve, and only in the face of death is it meaningful to act (Frankl, 1960; Frankl, 1967; Frankl, 1980).

Death, therefore, is seen as an indicator which manipulates individual behaviour. The fact that every person has only one chance to live a productive and fulfilling life means that he or she has the unique ability to develop according to his or her own will, to self-actualise and to aim at higher values (van der Westhüysen & Schoeman, 1989). It is when man accepts his finiteness and finds meaning in his suffering that he achieves mental health and maturity (Frankl, 1980). Man no longer postpones living until some future moment but realises that one can only really live in the present. In the face of death as absolute *finis* to his future and boundary to his possibility, it is imperative that he utilises his life to the utmost by not allowing a singular opportunity to pass by unused (Frankl, 1967; Misiak & Sexton, 1973). Finality is therefore not only an essential characteristic of human life, but also a real factor in its meaningfulness (Frankl, 1960). This meaning greatly influences a person’s views concerning life and death.

Because death is final, life never ceases to have and retain meaning to the very last moment (Frankl, 1960; Frankl, 1967, Frankl, 1980). Thus any form of suicide deprives man of the opportunity to fully grow and be fulfilled as a result of his suffering. A person who commits suicide immortalises only the past, without any reference to the future, and the life question remains unsolved (Frankl, 1980). Even when facing an ineluctable fate, for example an incurable disease, man still has the opportunity to find meaning in his suffering. What matters is the stand he takes in his predicament. Man is ready and willing to shoulder any suffering as soon and as long as he can find meaning in his pain (Frankl, 1967; Frankl, 1985). Faced with impending death, many patients start to think more deeply about their suffering and the way it brings meaning to life (Latimer & McGregor, 1994). However, when meaning in life is found absent, euthanasia may be seen as a way out (Levine, 1997; MacDonald, 1995).

2.4.4 Health Status

With the eradication of many childhood illnesses and infectious diseases such as smallpox, more people are surviving to an age at which they risk death from chronic, degenerative diseases of the circulatory and respiratory systems and cancers. Therefore, the longer a person lives, the greater the risk of exposure to carcinogens, impaired immune function, alterations in host genome and declining physical and mental conditions (Corr, 1995; Friedberg, 1993; Friedman, 1964; MacDonald, 1995; van der Maas et al., 1991; van der Maas et al., 1996).

Medical advancement and the scientific and technological resources at society's disposal have consequently considerably reduced the rate of premature mortality (Hayflick, 1987; Russell, 1977; Seale & Addington-Hall, 1994). At the same time, it has substantially increased the number of individuals who may survive in a condition marked by an unsatisfactory quality of life. Life can now be prolonged by means of modern technology in situations where the decision is based largely on technical criteria rather than on considerations for the patient (Key, 1989) who may be suffering grave pain. Dare (1987) estimates that although some cancer patients (30-40%) never experience any pain, approximately 40% of patients experience severe pain at some time during their illness,

while about 5% of all cancer patients suffer intolerable pain which cannot be controlled (Dare, 1987; Baines, 1984; Daut & Cleeland, 1982). In these circumstances it is only natural that euthanasia is seen by many as an escape from indefinite suffering and pain caused by illness (Levine, 1997; MacDonald, 1995).

When the pain suffered by a terminally ill patient reaches a certain level, consciousness becomes constricted to the point where choices other than suicide cannot be appreciated (Koenig, 1993; MacDonald, 1995). It is interesting to note that the suicide rate for those aged 65 and over is much higher than that of the younger population (Dacey & Travers, 1994; Larue, 1996; Rabe, 1993). Motivations for suicide among the elderly include poor health, loneliness, the loss of independence, and reliance upon others (Dacey & Travers, 1994; Larue, 1996; Rabe, 1993).

Many proponents argue that euthanasia and physician-assisted suicide should be considered and evaluated as an alternative for terminally ill persons who suffer continuous pain, where the person has expressed autonomy over life and death and has chosen the moment and means of death (Dacey & Travers, 1994; Larue, 1996). In most cases, society will permit a terminally ill patient to commit suicide by declining treatment. However, the issue becomes much more complex when a person needs or requests help, either in the form of providing the means to kill or asking someone to commit the actual killing.

It is important, once again, to stress that there is an increasing need to research the relevance of euthanasia with regards to AIDS and the effect it has on society. However, since cancer is still the biggest cause of death in South Africa (Hospice Annual Report, 1999), this study focuses only on the effect of cancer.

Euthanasia presents an ethical and moral question, the answer to which is influenced by every sphere of human existence. No wonder then, that this is a subject which has given, and still gives rise to fierce and well-developed arguments, both in favour of and against the legalisation of euthanasia.

2.5 Arguments in favour of euthanasia

The recent growth of voluntary euthanasia movements, such as the Voluntary Euthanasia Society in the UK, the Hemlock Society in the USA and the South African Voluntary Euthanasia Society (SAVES), has given rise to the notion that people facing serious problems, especially those with painful, disfiguring or disabling terminal illnesses, should be encouraged and assisted in considering suicide as a rational solution (Brown, Henteleff, Barakat & Rowe, 1986).

Arguments in favour of euthanasia focus on autonomy, mercy and a patient's right to be free from paternalistic state intrusion (Schanker, 1996). The *autonomy argument* is considered to be the ultimate extension of self-determination. The basis for this is the established right of privacy and the right to refuse treatment. The *mercy argument*, on the other hand, holds that where a terminal patient prefers death to continued, lingering life and is not willing to suffer torment, it is not immoral to help the patient die sooner. (Schanker, 1996).

2.5.1 **Autonomy**

Autonomy is seen as the linchpin of the right to die and is one of the core principles shared by almost every member of society. Johnson (1996) argues that part of our social contract is the principle that the individual retains whatever is not surrendered to the state. In an open, pluralistic and democratic society, an individual thus has the right to determine what is done to his or her body (Kurtz, 1996). Accordingly, an individual has a right to choose death over a life of pain and suffering, provided the decision to die is well informed, is made only after careful thought and deliberation (Schanker, 1996; Wennberg, 1989), and is made by a competent person. By definition this means that a knowledgeable, communicative understanding of the exact consequences of the decision should be present (Appelbaum & Grisso, 1988; Roth, Meisel & Lidz, 1977).

Harris (1994) noted that it is not wrong for individuals who do not value life to wish for death or to value death more than life. Ultimately, consideration of quality of life should not involve a comparison between different human lives. In some circumstances, to prolong or postpone death can reasonably be seen as non-beneficial to the patient. An example of such a circumstance is the case where a patient suffers excruciating, intractable and prolonged pain (Key, 1989). Studies conducted by van der Maas et al. (1991; 1996) showed that over 17% of patients in The Netherlands who chose euthanasia did so because of unbearable pain and that 82% of physicians shortened patients' lives by giving them a high dosage of opioids to alleviate pain and/or other symptoms. The act of shortening a person's life to end unbearable pain was shown to be supported by over 80% of the British population (Wise, 1996).

2.5.2 Mercy

(a) Medical opinion

Due to the successes of medical science and technology, medical advancements have considerably reduced the rate of premature mortality and have enabled physicians to keep the body functioning long past its natural span and long after mind and spirit have ceased to exist. The ability to prolong life almost indefinitely by artificial means has, in certain cases, produced what some have called a living death (Russell, 1977; Key, 1989). General practitioners and hospital consultants in the United Kingdom support changes to euthanasia legislation (Ward & Tate, 1994). 56% of Michigan physicians (Bachman et al., 1996), 60% of physicians in Denver (Angell, 1988), over 60% of physicians in the Midwest of America (Anderson & Cadell, 1993) and 51% of Alberta (Canada) physicians (Kinsella & Verhoef, 1993) also favour changes to euthanasia legislation. In The Netherlands, where euthanasia is legal, the majority of Dutch physicians view the application of euthanasia in certain cases as an accepted element of medical practice (van der Maas et al., 1991).

Although actions to shorten a patient's life are still illegal in South Africa and many other countries, many patients beseech their physicians to hasten their deaths. 32% of physicians in the United Kingdom (Ward & Tate, 1994), 29% in Australia (Kuhse & Singer, 1988), 12% in South Africa (Eads, 1997) and 53% in The Netherlands (van der Maas et al., 1996) report that they have complied with such requests.

(b) Palliative care

Opponents of euthanasia argue that palliative care is the answer to minimising requests for euthanasia. However, the effects of palliative care are limited in those cases where the patient's suffering, more often emotional than physical, cannot be fully relieved (Pollard & Winton, 1993). It should be considered that many health care professionals cannot properly assess pain and other complications in dying patients, while many possess limited skills for controlling pain (Chapman & Gavrin, 1996). Even with the best of care, according to Quill, Meier, Block and Billings (1998), a small number of dying patients will still experience pain and suffering that cannot be satisfactorily relieved, and some of these patients will request assistance in hastening their deaths.

According to the Episcopal Diocese of Washington (1997) individuals have lost control over when and how they die. There can be no doubt that the lives of some elderly patients are extended considerably by nursing and medical care. Skilled nursing care, according to Baker (1976), can maintain the life of a frail, elderly patient whose general condition is so bad that in the past he or she would have died. He argues that there is considerable doubt whether this extension in any way benefits the patient (Baker, 1976). Many illnesses, such as AIDS, can be very cruel indeed, particularly under modern conditions of treatment where the pain and suffering are extended indefinitely. Comparing the indefinite extension of life to the intolerable level of pain and suffering, the justification for the legalisation in favour of euthanasia can be appreciated.

(c) Doctrine of double effect

The doctrine of double effect, first coined by the Roman Catholic Church (morally approved in 1957 by Pope Pius XII), holds that it is wrong to intentionally commit a wrongful action, even if it is to achieve the good consequences that will follow. It is, however, permissible to do a “good” act knowing also that some “bad” consequences will follow (Addendum D; Darley et al., 1996; Hessing et al., 1996; Russel, 1977; Twycross, 1996). An example of this is the use of narcotics and/or analgesics, as a “good” act, to relieve pain, nausea, or shortness of breath which could hasten or cause the patient’s death when given in excess doses, a “bad act” (Koenig, 1993; Wilks, 1999). Euthanasia is often defended under the banner of the doctrine of double effect.

2.5.3 Religion

(a) Playing “God”

Russell (1977) argues that it is absurd to argue that “man must not usurp God’s power” and “God alone must determine when life shall begin and when it shall end”, since man already exerts great power over both birth and death. He furthermore asserts that it seems doubtful that God’s will would require doctors to persist in prolonging life as long as possible regardless of the patient’s suffering and wishes or beyond the point where life has meaning to him.

Wennberg (1989) states that when a person is rendered permanently comatose:

“ ...it would seem that the divine purpose for that life can no longer be realised within the sphere of earthly existence. In such circumstances, personal life is at an end, and there remains only a defectively functioning biological organism where once there was a person. The divine purpose for human life requires the presence of personal consciousness, which in the case of the permanently comatose person has been lost since there can be no moral and spiritual growth, no exercise of human agency, no growing closer to God and neighbour, no service or worship

offered in love and gratitude - in short, nothing that invests human life with its special value. Where there is only biological or somatic human life, the supreme value of service is no longer attached to the individual, and biological or somatic death may be allowed to proceed unimpeded.” (p. 88)

(b) The views of churches

The Anglican Church stresses the idea that it is the person rather than the body that is sacred (Russell, 1977). It furthermore seems to be an incontrovertible proposition that when man is confronted with suffering which is wholly destructive in its consequences, a doctor’s duty of care for his patients includes enabling those who are dying to die with dignity. There is no moral obligation on doctors to hasten or prolong dying by artificial means, and pain-killing drugs may be administered even though they may shorten life (Larue, 1996).

Methodists also accept relief of suffering as an aim in the care of the dying person rather than focusing primarily on prolongation of life. Holy dignity should be preserved through loving, personal care without efforts to prolong terminal illness and in such a way that the church and the human community embody mercy and justice for all (Larue, 1996).

2.5.4 Regulation of euthanasia

Many opponents of euthanasia argue that there exists a legitimate concern that adopting euthanasia practices as a matter of policy and law would present dangers to society. However, there is much to be said for permitting or regulating behaviour. Simply making behaviour illegal is not an adequate solution since it usually results in driving the behaviour underground, often with disastrous consequences for society. This has been clearly illustrated by the banning of alcohol (Lester, 1996). Advocates contend that allowing a small number of assisted suicides under carefully controlled and narrowly restricted conditions would be better than acceding to the secret and unregulated activities

(Bachman et al., 1996) reported in South Africa (Eads, 1997) and in many other countries (van der Maas et al., 1996; Ward & Tate, 1994).

To avoid serious abuses of assisted suicide or euthanasia and the subsequent devaluation of human life, supporters of these acts suggest the careful regulation of such practices by law (Episcopal Diocese of Washington, 1997; SALC, 1997). The situation in The Netherlands is cited as an example. The Dutch have established conditions that must be met before physicians may administer euthanasia. Where physicians apply euthanasia without such conditions being satisfied, they risk legal prosecution (Sagel-Grande, 1998; Twycross, 1996). According to the Dutch, the best way to minimise the possibility of abuse is to limit the availability of euthanasia to competent patients who request the act on the basis of their current situation instead of their hypothetical, future position. Use of such practices would be sharply limited, since euthanasia would also be denied to incompetent patients with an advanced directive (Angell, 1988).

The South African Law Commission (1997) has shown its support of this procedure by suggesting that the criteria set out for legislation in favour of euthanasia should stipulate specific requirements which must be met before euthanasia could be administered. These requirements, which are similar to those used in The Netherlands, are the following: the patient must be suffering from a terminal illness, the suffering must be subjectively unbearable, the patient must be competent and give consent, and two medical practitioners must certify the existence of the mentioned conditions (SALC, 1997).

It is interesting to note that over 75% of the respondents interviewed by Blendon et al. (1992) in America, believed that the law should sanction the withdrawal of life support or life-sustaining treatment where a terminally ill patient requests it. Such sanction is seen as permitting individuals to have more personal control over their quality of life and death. In comparison with this, 90% of Edmonton respondents (Genuis, Genuis & Chang, 1994), 90% of the British population (Wise, 1996) and 48% of the Michigan sample (Bachman et al., 1996) supported a competent patient's right to have life support withdrawn on request.

2.6 Arguments opposing euthanasia

It is said (Chochinov & Wilson, 1995; Hendin & Klerman, 1993; Latimer & McGregor, 1994) that a society's moral integrity can be measured by the way it treats its most frail and vulnerable members. Many authors (Farsides, 1996; Wennberg, 1989) agree that how one views life determines how one views death and which type of death one considers appropriate. Opponents of euthanasia argue that its legalisation will reflect the movement away from efforts to improve the care of those most in need. Instead, legalisation will amount to acceptance of the view that death is the preferred solution to the problems of illness, age, and depression (Hendin & Klerman, 1993).

Arguments against euthanasia are more familiar than arguments in favour of it. Strong legal, religious and cultural taboos against the taking of human life reflect the supreme value placed on human life. Legitimate concerns exist that any compromise of this position might lead to acceptance of the notion that euthanasia is appropriate for the individual patient under certain circumstances. Such compromise should be opposed, as it would lead to the devaluation of life (Angell, 1988). Related to this argument, according to Angell (1988), is the fear that devaluation would be selective and that euthanasia might occur too often among the weak and powerless in our society - the very old, the poor, and the handicapped.

Arguments against the legalisation of euthanasia focus on four major themes: the sanctity of human life, the slippery slope, the danger of abuse and the commitment by physicians to save lives.

The *sanctity of human life* argument emphasises the inviolability of our cultural prohibition against killing. *Slippery slope* arguments envision the legalisation of voluntary euthanasia as inexorably leading to forms of involuntary euthanasia and an attendant devaluation of human life. *Danger of abuse* arguments envision the coercion of patients by their families, doctors or health care workers to request euthanasia, and the

disregard of euthanasia guidelines by physicians and institutions (Darley et al., 1996; Schanker, 1996) who are *committed to saving lives*.

2.6.1 Sanctity of life

Coleman (1996) and Harris (1994) argue that life, being a sacred gift from God, is the ultimate value against which all other values are measured. Although sanctity of life is a concept of abstract and indeterminate nature, it helps one to adopt a particular consciousness that is needed to operate at a higher level. Thus preserving and protecting one's life is to honour the divine sovereignty over life and death (Dierick, 1983; Wennberg, 1989). Any act or omission intended to hasten death is therefore immoral and presumptuous since life ultimately belongs to God and the situations we are faced with are given for reasons not to be questioned. The fact that a person acts from pure motives does not alter this position (Coleman, 1996; Dierick, 1983; Uys & Smit, 1992; Wennberg, 1989).

According to Wise (1996), religious beliefs are powerful determinants of attitudes because religion deals with the highest level of meaning. It also offers concepts and methods for achieving the ultimate fulfilment possible in human life by enabling people to make sense of what happens to them. It is an important basis for self-worth, especially when founded on membership of a religious community which help the individual to find meaning in misfortune and who provide answers to questions relating to the meaning of life (Baumeister, 1991; Uys & Smit, 1992). Those for whom religion is a very important aspect of their lives are much less likely both to support legalisation and to consider personal involvement in euthanasia or assisted suicide, either as providers (physicians) or requesters (the public), than those for whom religion is less important (Bachman et al., 1996). Research confirmed that respondents' level of religious activity had a significant impact on their views relating to euthanasia. (Darley et al., 1996; Genuis et al., 1994; Kinsella & Verhoef, 1993; Leinbach, 1993). This is not surprising because, as Genuis et al. (1994) points out, end-of-life decisions challenge our definitions of life and death and the meaning we give to these events. This is proven by the fact that only 57% of very and

somewhat religious people in the study by Blendon et al. (1992) support euthanasia, while 84% of those describing themselves as “not very” and “not at all” religious favour euthanasia.

(a) Christianity

Since almost 80% of the population in South Africa and 77.8% of the population in the Western Cape profess the Christian faith, the influences of the church and its teachings have a great influence on the community (Burger, 1999; Orkin, 1999). Although the Zionist Church is the biggest church in South Africa – especially in the northern part of the country - Orkin (1999) argues that only 0.9% of the total population in the Western Cape belong to the Zionist Church. According to him the religious profile for the Western Cape consists of 20% of the population belonging to the Dutch Reformed Church, 9.3% to the Anglican Church, 6.9% to the Islamic faith, 6.8% to the Pentecostal Church, 6.6% to the Roman Catholic Church, 5.7% to the Methodist Church, 0.4% to Judaism, 0.1% to Hinduism, while 5.2% have no religious convictions.

(i) Dutch Reformed Church

The Synod of the Dutch Reformed Church, the church with the largest representation of believers in the Western Cape (Orkin, 1999), believes that Christian ethics and the Bible condemn active euthanasia. According to the Synod, the Bible (Gen. 1:7; Ps. 36:7, 41:3, 16:5; 1Pet. 5:7, Heb. 12:2; Rom. 11:36) makes it clear that God is the Creator, Keeper and Finisher of human life.

1Cor. 6: 19-20. “ Do you not know that your body is a temple of the Holy Spirit, who is in you, whom you have received from God? You are not your own; you were bought at a price. Therefore honour God with your body.”

Life therefore belongs to God and only God may decide to end life (Algemene Sinode, 1982).

(ii) The Roman Catholic Church

The 1980 declaration on euthanasia by the Sacred Congregation for the Doctrine of Faith (Larue, 1996) states that everyone has the duty to lead his or her life in accordance with God's plan. Life is entrusted to the individual as a good that must bear fruit on earth, but which finds its full perfection only in eternal life. The declaration continues by saying that to intentionally cause one's own death is wrong since such an action on the part of a person amounts to a rejection of God's sovereign and loving plan (Larue, 1996).

The Catholic Church does, however, distinguish between active and passive euthanasia. In general active euthanasia is not permitted, while passive euthanasia and the "double effect" are more acceptable, taking into account the intention of the person performing the action (Addendum D; Darley et al., 1996; Hessing et al., 1996; Twycross, 1996).

According to Cawcutt (Addendum D), the Catechism of the Catholic Church (published by Pope John Paul II in October 1992 in the form of an "Apostolic Constitution") - which is the official teaching of the Catholic Church - clearly states the modern Church's view on euthanasia:

"Catechism 2277: Whatever its motives or means, direct euthanasia consists in putting an end to the lives of handicapped, sick or dying persons. It is morally unacceptable. Thus an act of omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator. The error of judgement into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded.

Catechism 2280: Everyone is responsible for his life before God who has given it to him. It is God who remains the sovereign Master of life. We are obliged to accept life gratefully and preserve it for His honour and the salvation of our

souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of.”

Throughout history, Roman Catholics have tended to place much emphasis on the authority of the Church and its leadership (Anderson & Cadell, 1993). The adherence to the teachings of the Church can clearly be seen in the fact that Roman Catholics have mostly been found to oppose euthanasia (Anderson & Cadell, 1993; Coleman, 1996; Kalish, 1963; Larue, 1996).

(iii) African Christian Churches

According to Hammond-Tooke (1998), most African Christian Churches, of which the Zionist Church is the largest in South Africa (Hammond-Tooke, 1998; Orkin, 1999), still retain a belief in continuing ancestral involvement in their lives as it gives them a feeling of comfort and protection. Broster (1982) argues that Africanisation of the Christian religion, moulded on tribal belief, is occurring rapidly. This is clear from the belief of many members of the African Christian Churches in the possible existence of witches, which they redefine within their own theological terms as demons (Hammond-Tooking, 1998).

African Christian Churches find their roots within Protestantism (Broster, 1982; Hammond-Tooking, 1998; Wilson et al., 1952). However, they have a strong resemblance to the Pentecostal-type Christianity found in the USA (Hammond-Tooking, 1998). Both groups place great emphasis on the healing power of the Holy Spirit. The researcher of this study is of the view that the combination of the strong Protestant ethic of “thou shall not kill” and the traditional African belief that killing dooms the spirit of the killer, suggests that any act of self-killing would be frowned upon by the African Christian community of faith.

(b) Judaism

Judaism's life-affirming strand is very strong, even among those who no longer contend with the religion itself (Neuberger, 1995). Any form of self-killing is strongly opposed by the Talmud (Oosthuizen, 1988) and the fight against death and the desire to survive no matter what are common features of coping with the terminally ill in Jewish communities. The emphasis on life in Judaism is so great that to lose even a few minutes of it is seen as a terrible thing. Euthanasia is thus frowned upon (Larue, 1996; Neuberger, 1995, Oosthuizen, 1988).

(c) Buddhism

According to Larue (1996), Buddhist literature has not yet paid any attention to the subject of euthanasia. The closest link is found in the Buddhist teachings on suffering, as well as the Buddhist belief in a dignified life. Based on the doctrine of rebirth in Buddhism (Rinpoche, 1995), the Dalai Lama states that:

“Your suffering is due to your own karma, and you have to bear the fruit of that karma anyway in this life or another, unless you can find some way of purifying it. In that case, it is considered to be better to experience the karma in this life of a human where you have more abilities to bear it in a better way.” (p. 375)

Those who picture the world in a negative light, no matter what their circumstances and to the extent that they eventually want to end their lives, are considered by Buddhism as acting contrary to the freedom which can be obtained through enlightenment (Oosthuizen, 1988). Observing the teachings of Buddha entails living a good life in such a way that one gradually reaches nirvana - perfection – and enter a level where selfishness is gone and separate identity is no more. The search for this awareness may mean, however, that the Buddhist will not control pain by taking any drugs which could in any way blunt perception and impede peace and meditation (Neuberger, 1995), and

which could prevent him or her from achieving something worthwhile or even brilliant in the time remaining (Larue, 1996).

(d) Muslim

Devout and pious Muslims believe that death is part of God's plan and that a struggle against it is wrong. There is therefore no justification for taking a life to escape suffering, because life is always worth living (Larue, 1996; Neuberger, 1995). The Qu'ran (with reference to Sura 3:139; 4:93,95 and 16:63) strongly rejects any form of self-killing (Oosthuizen, 1988).

The acceptance of terminal illness and the desire to use it to surrender to the will of Allah, mean that a Muslim patient will often want less in the way of pain relief and more in the way of opportunity for prayer and contemplation. This is not to suggest that Muslims will reject pain relief - there is a strong anti-pain tradition within the religion - but Muslims will often accept the associated discomforts of pain and use the time of their illness for seeing family and surrendering to the situation (Larue, 1996; Neuberger, 1995).

According to the Islamic Code of Medical Ethics (Larue, 1996), mercy killing finds no support except in the atheistic belief that life on earth is followed by a void. Life, according to the teachings of the prophet Muhammad (Larue, 1996), is a value to be respected unconditionally and irrespective of other circumstances. Muslims recognise that the economic cost of maintaining the incurably ill and the senile are growing concerns, however, in the Islamic faith, values take priority over prices. Caring for the weak, old and helpless is a value in itself for which people should willingly sacrifice time, effort and money (Larue, 1996).

(e) Hinduism

Followers of the Hindu religion strongly condemn euthanasia (Ganga, 1994). Hindus believe that the issue should be viewed in accordance with the laws of the country (Larue, 1996). However, if circumstances arise where euthanasia is the only option, it may be supported. Ganga (1994) explains that a person is allowed to end his or her life in certain circumstances, for example where such a person is contaminated by an incurable disease which, if it spreads, will be harmful to the whole community. However, some Hindu theologians view self-killing on the grounds of intolerable pain as a crime, and believe that one has to face the realities of life (Ganga, 1994).

Killing does not present a means to escape suffering, because the consequences of killing oneself are much more serious than the problems themselves. According to Hindu belief (Ganga, 1994), the soul of a person leaves the body only when it is the will of the Lord. If the soul leaves the body prematurely, the soul will roam about causing mischief and will not be able to evolve spiritually (Ganga, 1994). Hinduism believes in the transmigration of souls and sees self-killing as futile (Oosthuizen, 1988) since a new existence, in which he or she will receive rewards for good deeds done or punishment for bad deeds committed, awaits a person after his or her present life. Self-killing will therefore set a person back in his or her attempt to reach his or her eternal destiny (Oosthuizen, 1988).

2.6.2 “Slippery slope” argument

Schanker (1996) argues that the current acceptance of voluntary euthanasia, active or passive, masks the failure of health care systems to address the needs of the terminally ill, elderly, and the indigent. Pollard and Winton (1993) argue that the legalisation of euthanasia in any of its forms would fundamentally alter the concept of what constitutes medical treatment and the practice of medicine. Legalisation could create a disincentive to search for new treatments and to give high quality care to all patients, especially those who suffer the most difficult and unpleasant illnesses.

Similar concerns were raised in the Edmonton sample, where 63% of the sample felt that legalising euthanasia in the case of patients with terminal illnesses would create the opportunity to apply euthanasia for other reasons. 76% felt that legalising euthanasia for terminally ill patients in severe pain would have the same result (Genuis et al., 1994).

Opponents furthermore stress that legalising euthanasia and assisted suicide would have serious unintended consequences, and that any gains from accepting the practice are not worth the risks (Bachman et al., 1996).

2.6.3 Dangers of abuse

(a) Emotional fluctuation

A review of literature, as previously mentioned, indicates that persons who face impending death may suffer from mood swings. Depression and hopelessness lead to the undervaluing of all potentially positive outcomes of medical treatment. Ganzini, Lee, Heintz, Bloom and Fenn (1994) showed that feelings of hopelessness and pessimism, and the excessive emphasis on the burdens of treatment experienced by those suffering from depression, may temporarily alter a person's personal formula for weighing risks and benefits. Therefore the withdrawal of life-support should be discouraged and aggressive treatment of depression should proceed.

(b) Financial burden argument

Brammer, Shostrom and Abrego (1989), as well as Saunders (1992) argue that the individual can only be understood within the context of his or her friendships and broader social groups. Thus, self-regarding attitudes are determined by the attitude of others toward them and therefore, much anxiety originates in an interpersonal context. Furthermore, the quality of an individual's life is affected by the quality of his or her environment and culture (Megone, 1992). According to Megone (1992), this can

contribute to some people being the victims of old age, poverty, homelessness, unemployment, or even illnesses.

With the rising cost of health care many governments, private insurers, and employers had to set limits on health care coverage (Schanker, 1996). Society, Johnson (1996) argues, with pervasive societal pressures and demands can force the medically indigent, such as the elderly, terminally ill and poor, to die earlier simply to free up resources for the rest of society. The risk would be especially great where an elderly person feels there is no other option, or fears being a financial and emotional burden to society (Hendin & Klerman, 1993; Koenig, 1993; Lester, 1996; Pellegrino, 1991; Schanker, 1996).

Research done in America and Britain illustrates this point. It was found that the main reason Americans would consider ending their lives stemmed primarily from fears of being a burden to their families (Blendon et al., 1992). 51% of a British sample agreed that a patient should be granted a request for euthanasia if they were permanently and completely dependent on relatives, even though they might not be in pain or in danger of dying (Wise, 1996).

On the other hand, research conducted by Genuis et al. (1994) indicated that 65% of the Edmonton population oppose the right to euthanasia for disabled, elderly persons on the basis that they feel themselves a burden to their families. 75% opposed euthanasia for reasonably healthy, elderly persons who no longer enjoy life because of loneliness, fatigue and various aches and pains.

The financial burden argument is labelled by proponents as scare mongering. They refer to The Netherlands as the model example, where such practices do not commonly occur. However, as van der Wal & Dillmann (1994) point out, almost all patients (99.4%) in The Netherlands have health care insurance and 100% of the population is insured against the cost of protracted illness. Therefore, there are no financial incentives for hospitals, physicians, or family members to stop the care of patients.

The picture in South Africa, however, is very different. Many citizens are poor and these patients are by necessity discharged early to be nursed at home - the purpose being to cut down on medical care costs (Jacobs, 1993). These patients are thus deprived of any possible life prolonging interventions. Should voluntary euthanasia be legalised before the financial stressors in our health care system are reasonably ameliorated, the potential for abuse is great, as Schanker (1996) argues. In the coming decades, the elderly population will increase dramatically, and if the spread of AIDS and social ills associated with poverty continues unabated, the health care system will be burdened far beyond its present capacity (Schanker, 1996).

2.6.4 Physician's role

(a) Physician's authority

Another concern of opponents of the legalisation of euthanasia is that many people are socialised to regard a physician as an authority figure. Therefore they see themselves as having little autonomy in health care matters and willingly allow physicians to make end-of-life decisions (Cicerelli, 1997; Gunasekera, Tiller, Clements & Bhattacharya, 1986). Physicians have their patients' lives in their hands and may decide to end it prematurely. Research by van der Maas et al. (1991) confirms this - 98% of nursing home physicians in The Netherlands have acknowledged that they have withdrawn treatment or not started it, knowing that the treatment might have prolonged the patient's life. The premature ending of the life of another person deprives that person of something they value, namely life itself (Harris, 1994).

(b) Physician's commitment

A doctor has twin obligations to observe life and to relieve suffering. Preserving life becomes increasingly meaningless when a terminally ill patient is close to death. The emphasis shifts and relieving suffering becomes paramount. Even here, however, the

doctor is obliged to achieve his objective with minimum risk to the patient's life (Twycross, 1996).

Physicians and health care delivery systems face increasing pressure to practise more efficiently, expediently and more cost-effectively (Latimer & McGregor, 1994). With the severe constraints on health care facilities in South Africa and the totally inadequate allocation of resources it is doubtful that physicians could continue to care for seriously ill patients (Latimer & McGregor, 1994; Rogers, 1996; Sidiropoulos et al., 1998). Physicians, according to Latimer and McGregor (1994) as well as Rogers (1996), would have to start to acknowledge the limits of "striving obviously to keep alive" and "allowing to die".

However, some authors (Koenig, 1993; Pollard & Winton, 1993) are of the opinion that there would be little need to discuss euthanasia at all, if only doctors communicated effectively with patients and families, alleviated loneliness, mobilised family members to dispel feelings of abandonment, provided devices to limit disability, maximised autonomy and self-care by allowing patient participation in medical decision-making, and familiarised themselves with the principles and practices of palliative care.

(c) Palliative care

The main reasons for requesting euthanasia or assistance in suicide are usually severe patient distress, uncontrolled physical symptoms, depression, anxiety or severe existential distress (Cherney, Coyle, & Foley, 1994). Because all of these symptoms can be treated by better palliative care, Pellegrino (1991) argues that any such requests should be rejected.

The aim of palliative treatment is to obtain symptom control and a high quality of life even if life expectancy may be relatively short and the patient's health may be poor. The end goal is to help the patient achieve a peaceful death (Larue, 1996; Saunders, 1992; Seale & Addington-Hall, 1994). In essence, palliative care is an affirmation of life, even

in the face of impending death. There is thus a shift of goals from the cure and prolongation of life to the alleviation of psychological and spiritual suffering, the relief of pain and other symptoms, and the enhancement of the meaning and quality of the patient's remaining life (Ebersole & Hess, 1998; Latimer & McGregor, 1994). Palliative care therefore utilises every relevant component of modern medicine to achieve maximal comfort, to alleviate fear and anxiety, to establish security and trust, and to encourage patient autonomy (Pollard, 1988).

Even in the traditional African setting palliative care is available in the form of traditional healers (*igqirha*) (Borster, 1982). A traditional healer's role in the treatment of cancer is to provide holistic care for the patient by administering herbs, providing wound care, giving psychosocial support to the patient and family, and performing rituals in accordance with the patient's cultural beliefs (Broster, 1982; Jacobs, 1993). Borster (1982) explains that the *igqirha* is inspired by the ancestral spirits to provide the right herb, plant, bark or roots to a terminally ill person. One example is the application of the roots of the sedge plant (genus *Cyperaceae*) to any person who is terminally ill (Borster, 1982). The effect of the plant is similar to a narcotic – numbing the central nervous system - but it also acts as an antibiotic and has properties that inhibits or destroys the growth of a foreign cells or organisms. Since traditional healers combine physical, social, emotional and spiritual attributes, they play a very important role in the care of patients (Jacobs, 1993).

Physicians have the responsibility to give comprehensive palliative care to terminally ill patients and their families throughout the dying process and to make every effort to explore, understand, and address suffering that persists despite their best efforts. Premature participation in options to shorten life may, according to Quill et al. (1998), reflect a lack of familiarity with appropriate measures to relieve suffering, pressures to contain cost, and the strain on health care providers or families to provide complex and emotionally demanding forms of terminal care. If doctors who care for the elderly, the dying and the disabled are not well trained in the principles and practice of good palliative care, and if the community does not know that better care is possible,

euthanasia will be seen by some as a reasonable alternative (Pollard & Winton, 1993). It is interesting to note that suicide is rarely considered by terminally ill elderly people whose needs are met in a palliative care setting and who are kept within the mainstream of life (Ebersole & Hess, 1998).

Opponents of euthanasia warn that until all dying patients and their families have ready access to the full continuum of skilled and effective palliative care services, the dilemma of euthanasia and assisted suicide cannot be addressed appropriately or safely. Such access should be a prerequisite of any consideration of the need to change legislation (Latimer & McGregor, 1994; Pollard & Winton, 1993). Research done by Quill et al. (1998) found that considerable end-of-life suffering could be eliminated if palliative care was more readily available. An analysis of 200 cases by Zylicz & Finlay (1999) showed that the majority of patients abandoned their request for euthanasia once appropriate care was offered.

(d) Experience and field of practice

Many doctors who have practised euthanasia have mentioned that they would be most reluctant to do so again (Anderson & Cadell, 1993; van der Maas et al., 1991). Physicians in the medical specialities of oncology and haematology, who in their daily work have close and continuous contact with dying patients, hold more restrictive attitudes than physicians in laboratory specialities (Førde et al., 1997). Thus, the doctors who had least contact with terminally ill patients were the most likely to support the legalisation of assisted suicide (Bachman et al., 1996). It is interesting to see that 52% of physicians in Michigan (Bachman et al., 1996) and 51% in Alberta (Kinsella & Verhoef, 1993) would not be willing to participate in physician-assisted suicide or voluntary euthanasia if these practices were legalised.

2.7 Legal

The problems posed for law and morality by the assertion of a right to die are complex (Key, 1989). Moral dilemmas arise and become progressively more serious as medical science develops and the body can be kept alive almost indefinitely with respirators, pacemakers, renal dialysis and artificial feedings (Key, 1989; Russell, 1977).

At the core of all modern legal systems lies the fundamental assertion that human life should be protected. Legal systems, regardless of specific variations in cultural or social context, recognise the value of human life by prohibiting homicide and punishing acts, which constitute a danger or serious threat to the lives of other human beings. The modern law reformer faces two central questions. Firstly, does an individual have a right to die? Secondly, do individuals have a right to let someone else die? There is an inherent tension between the public interest in improving community health standards and preserving life, on the one hand, and the individual's right to personal autonomy on the other (Key, 1989; van den Akker, Janssens & Ten Have, 1997).

2.7.1 **Religious dogma**

The most serious difficulty faced by those proposing a rule of law based upon religious dogma is that it will only be convincing to those who accept the religious viewpoint, that is, those who are already believers. Moreover, as Key (1989) points out, modern law is not and should not be dictated by popular religion. There should not exist a simple equivalency between sin and crime; all crimes should not be seen as sins, nor should all sins be seen as crimes. It has been argued, however, that a society may legitimately use the law to shape its basic institutions and practices to accord with its deepest convictions about right and wrong (Wennberg, 1989).

2.7.2 Present position

According to the present position in our law, it is unlawful to terminate a person's life in order to end his or her unbearable suffering, even if it is clear that death is inevitable and that the person is about to die. The intentional termination of such a person's life remains punishable, even where the suffering person expresses the wish to die (Ganga, 1994; Hiemstra, 1988; SALC, 1997). However it appears that the courts, while deeming such actions universally unlawful, have implicitly recognised the diminutive character of such crimes or the absence of moral blameworthiness in committing such crimes, by imposing remarkably light sentences (Ganga, 1994; Scott, 1998). It is society's attitude to the motive of these individuals, as construed by the courts, which is determinative (Scott, 1998).

However, where a person is kept alive artificially by a breathing apparatus or similar device while it is certain, according to medical evidence, that the person is in an irreversible, persistent, vegetative state and will never again be able to lead a meaningful existence, the courts have held that it would not be unlawful to disconnect the apparatus (SALC, 1997).

2.7.3 Proposed changes

The South African Voluntary Euthanasia Society (SAVES) promotes legislation that will protect the rights of the dying and will absolve medical practitioners from any form of liability should they comply with the wishes of a dying patient. In the light of a request by this organisation, the South African Law Commission (1997) has recommended a change in the present euthanasia legislation. It is hoped that the enactment of new legislation will achieve the following:

- provide for the termination of terminal illness,
- recognise the validity of a Living Will,
- recognise the power of attorney,

- achieve endurance of power of attorney after the principal has become mentally incompetent,
- provide for the competence of the court to issue an order suspending the artificial preservation of a patient's life, and
- provide the head of a medical institution with the power to suspend the continued treatment of a terminally ill patient.

If the proposed Act, as it stands in the Draft Bill on Euthanasia, is passed by parliament, South Africa will join The Netherlands in having the most liberal euthanasia law in the world (Eads, 1997). Labuschagne (1997) is convinced that a change in the current legislation will take place in due course.

2.7.4 Dutch model

According to sections 293 and 294 of the Dutch Penal Code, killing a person on request carries a maximum penalty of 12 years' imprisonment and the maximum penalty for assisting in a suicide is three years' imprisonment. In terms of section 289, terminating life without request amounts to manslaughter or murder. Consequently, everyone who commits euthanasia, assists in suicide or ends human life without request is punishable and exemption from punishment is only possible in terms of the general rules. Such a general reason for exemption from punishment can be found in section 40 of the Dutch Penal Code: "A person who commits an offence as a result of a force he could not be expected to resist (*overmacht*) is not criminally liable" (Sagel-Grande, 1998).

However, a new proposal for the procedure of euthanasia was introduced after 1996 in The Netherlands. Each case of euthanasia will now be scrutinised by the regional commission composed of physicians, ethicists, lawyers and other professionals. Not only the procedure itself but also the motives behind the act will be subjects of interest (Zylicz & Finlay, 1999).

The Dutch model is held by some to show that voluntary euthanasia can be embraced by a society in a controlled manner and monitored effectively (Twycross, 1996).

2.7.5 Conclusion

As a direct result of improvements in the medical field, better health care and political and economic infrastructure reforms (Hayflick, 1987; Seale & Addington-Hall, 1994; van der Maas et al., 1991), 9.6% of the South African population are now older than 65 years (Central Statistical Service, 1996). The ageing population has introduced new issues into society, such as increased numbers of terminally ill people requiring care (Hospice Annual Report, 1999); limited health care resources (Kastenbaum & Schmitz-Scherzer, 1987; Latimer & McGregor, 1994), and the influence of life preserving techniques (Seale & Addington-Hall, 1994).

South Africa is presently facing proposed changes to the legislation on euthanasia (South African Law Commission, 1997). The shift in favour of voluntary euthanasia highlights the above-mentioned issues. If the Draft Bill on Euthanasia is passed by parliament, South Africa will join The Netherlands in having the most liberal euthanasia law in the world (Eads, 1997).

Both sides of the euthanasia debate are fiercely argued. Those favouring euthanasia focus on autonomy, mercy and a patient's right to autonomy (Harris, 1994; Johnson, 1996; Kurtz, 1996; Schanker, 1996; Wise, 1996). Opponents on the other hand, focus on arguments such as the sanctity of human life, the slippery slope, the danger of abuse and the commitment made by physicians to save lives (Coleman, 1996; Darley et al., 1996; Harris, 1994; Johnson, 1996; Pollard & Winton, 1993; Schanker, 1996).

The problems posed for law and morality by the assertion of a right to die, when a person's body can be kept alive almost indefinitely, are complex (Key, 1989; Russell, 1977). Four variables which have a significant influence on a person's view of life and death were identified from literature: age, ethnicity, meaning in life and health status

(Baumeister, 1991; Comaz-Diaz & Griffith, 1988; Koenig, 1993; MacDonald, 1995; Rogers, 1996). These were used in the present study to determine the attitudes of the elderly towards euthanasia.

Chapter 3

METHOD OF RESEARCH

This study investigated the variations in cultural, religious and health backgrounds as well as purpose and meaning in life, in order to establish the influence of such variables on the attitudes of older adults towards euthanasia.

3.1 Formulation of research questions

The literature on euthanasia predicted that people of different ages, from different ethnic and religious backgrounds would have different attitudes towards euthanasia. However, because so little literature and data exist which relate to a cross-cultural investigation into the attitudes older adults have towards euthanasia, it has been decided to postulate questions rather than hypotheses. The following questions resulted from the literature discussed above:

- Does age influence a person's views towards euthanasia?
- Do people from different ethnic groups hold different views regarding euthanasia?
- Does meaning in life influence a person's attitude towards euthanasia?
- Do people who subjectively express poor health favour euthanasia more?

3.2 Subjects and data collection procedures

A list of all the homes for the aged in the Cape Town Metropolis was obtained from the provincial administration of the Western Cape's department of social welfare. Every home for the aged in the Cape Town Metropolis had an equal chance of inclusion. The homes in Gugulethu, Kraaifontein, Kuilsriver, Lotus River, Milnerton, Observatory, Retreat and Rondebosch were selected by a simple random sampling method described by Babbie (1992). These homes were representative of all socio-economic and ethnic groups of the general, elderly population in the Western Cape.

Once the homes were identified, permission was obtained from the management to approach the residents. Another simple random sampling was conducted to identify an equal number (forty (40)) of respondents from the African (predominantly Xhosa), Coloured and European communities - one hundred and twenty (120) respondent in total. The respondents were all aged 65 years or older and came from all socio-economic, academic and religious walks of life. Table 1 indicates the frequency distribution of these 120 older adults. For the purpose of this study, older adults who were found not to be of sound mind (*compos mentis*) were excluded.

A qualitative field study was conducted through interviews. Participation in this study was on a voluntary basis and each respondent's anonymity was insured by means of a private interview. No names or any other personal information were recorded. Each person's privacy and uniqueness was furthermore also respected and insured by means of sensitivity and a signed consent form (Addendum E). Once a participant showed any distress or discomfort with any of the questions, the researcher suspended the interview and re-assured the participant.

Table 1
Results of the Biographical Questionnaire (N=120)

		Frequency	Percentage
<u>Sex</u>	Male	39	32.5%
	Female	81	67.5%
<u>Age</u>	65-69	27	22.5%
	70-74	27	22.5%
	75-79	23	19.2%
	80-84	22	18.3%
	85+	21	17.5%
<u>Language</u>	Afrikaans	47	39.2%
	English	38	31.7%
	Xhosa	33	27.5%
	Other	02	01.7%
<u>Ethnic Origin</u>	African	40	33.3%
	Coloured	40	33.3%
	European	40	33.3%
<u>Academic Background</u>	Part of Secondary	78	65.0%
	Finished Secondary	20	16.7%
	Part of Tertiary	4	03.3%
	Finished Tertiary	18	15.0%
<u>Marital Status</u>	Married	17	14.2%
	Widowed	58	48.3%
	Divorced	11	09.2%
	Separated	4	03.3%
	Never married	30	25.0%
<u>Religious Belief</u>	Roman Catholic	19	15.8%
	Protestant	97	80.8%
	Jew	00	00.0%
	African	01	00.8%
	Other	02	01.7%
	Agnostic	01	00.8%
<u>Level of religiosity</u>	Very religious	71	59.9%
	Regular worshipper	29	24.2%
	Occasional worshipper	13	10.8%
	Not active	07	05.8%
<u>Attendance</u>	Once a year	08	06.7%
	Twice a year	03	02.5%
	More than twice a year	05	04.2%
	Once a month	04	03.3%
	Twice a month	06	05.0%
	Once a week	34	28.3%
	More than once a week	60	50.0%
<u>Health</u>	Excellent	19	15.8%
	Good	47	39.2%
	Fair	33	27.5%
	Poor	20	16.7%
	Terminally ill	01	00.8%
<u>Health interfered</u>	Not at all	41	34.2%
	Not very often	20	16.7%
	Some of the time	32	26.7%
	Most of the time	27	22.5%
<u>Pain</u>	Yes	41	34.2%
	No	79	65.8%

It is interesting to note that an almost equal distribution of the age groups and language groups participated. Since none of the respondents were Jewish, Moslem, Buddhist or atheist, these frequencies and percentages were excluded from this table.

3.3 Measuring instruments

Each respondent was individually interviewed in the privacy of his or her own room to ensure anonymity and objectivity, and was asked to complete three questionnaires. A *Basic demographic questionnaire* (Addendum A), a Holloway et al. (1995) *Euthanasia Attitude Scale* (Addendum B), and *The Purpose In Life Test* (Addendum C) were used. The researcher read each question and statement, explained any uncertainties and recorded the responses in written format.

3.3.1 Euthanasia Attitude Scale

The Euthanasia Attitude Scale was developed to assess the general attitude a person has towards end-of-life decisions. This scale further investigates patients' rights issues, the role of life-sustaining technology, the physician's role, and values and ethics. Holloway et al. (1995) suggests that the scale may be useful for both research and educational purposes. It may help researchers assess how different variables affect attitudes toward euthanasia in a more reliable manner than has previously been possible.

The questionnaire consists of thirty-five seven-point Likert-type questions of which half were written in the affirmative (pro-euthanasia) and half in the negative (anti-euthanasia) form. The questions furthermore 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). Higher scores indicated more positive, accepting attitudes towards the practice of euthanasia. The questionnaire has excellent psychometric properties, such as stability, internal consistency, discriminant validity, and test-retest reliability. Although the test was standardised for the American population, the

reliability score for this specific study using the Euthanasia Attitude Scale had an Alpha of 0.55. There exists no data confirming if the test has cross-cultural validity.

3.3.2 Purpose In Life Test

The Purpose In Life Test (PIL) is an attitude scale constructed from the orientation of Logotherapy – a system of existential therapy – developed by Viktor Frankl (Crumbaugh & Maholick, 1969). The aim of the test is to measure Frankl's basic concept of "existential vacuum" (Crumbaugh & Maholick, 1969), which he (1985) defined as the failure to find a meaning and purpose in life. Frankl believed that man seeks primarily to find meaning and purpose in human existence. When he fails to find a meaning and purpose that gives his life a sense of unique identity, he experiences an "existential vacuum" (Crumbaugh & Maholick, 1969).

The PIL has proven to be useful in the individual counselling of students in vocational guidance, in rehabilitation work, in treatment of both in-and-out patient neurotics, and in group administration for research purposes (Crumbaugh & Maholick, 1969).

The PIL consists of twenty scaled item questions. Each question is a statement with two opposites to choose from. The respondent has to place him- or herself on a seven-point scale closest to the answer which represents him or her best. Scoring is done by adding all the responses together, with the mean at 102 and the over-all estimated standard deviation at 19. Therefore any score of 102 or above will suggest the presence of purpose and meaning in life (Crumbaugh & Maholick, 1969).

The questionnaire has excellent psychometric properties with a high reliability Alpha coefficient ranging between 0.81 and 0.92 (Crumbaugh & Maholick, 1969). However, the test was not standardised for the South African population because raw scores were used, but the researcher found that the test's reliability score for this specific study had an Alpha of 0.72. The PIL furthermore also has three parts, but only the results from part

one was reported for the purpose of this study, since part two and three was purely qualitative.

3.4 Statistical techniques used

An analysis on the raw scores of the collected data was done by the computer software programme “Statistical Package for Social Sciences” (George & Mallery, 1999).

Chapter 4
RESULTS

The results of the study and the statistical inferences from these results are given within this chapter.

The aim of this study was to research older adult's views towards euthanasia and the influence of specific variables on these views. Therefore, three questionnaires were used, as discussed in the previous chapter.

Table 2 indicates the mean and standard deviation of each demographic variable towards euthanasia, while Table 3 shows the results of an ANOVA analysis of the total Euthanasia Attitude Scale and Biographical Variables.

Table 2

Descriptive Analysis of Euthanasia Attitude Scale and the Biographical Variables

		x	SD
<u>Age</u>	65-69	80.44	19.04
	70-74	83.33	18.86
	75-79	89.70	16.66
	80-84	90.27	20.21
	85+	91.57	17.60
<u>Ethnic Origin</u>	African	84.98	20.94
	Coloured	84.55	17.53
	European	90.33	17.54
<u>Language</u>	Afrikaans	84.26	16.37
	English	91.29	17.91
	Xhosa	83.79	21.47
	Other	100.00	35.36
<u>Marital Status</u>	Married	90.00	19.21
	Widowed	88.74	19.00
	Divorced	89.00	21.32
	Separated	81.75	9.00
	Never married	80.37	17.47
<u>Health</u>	Excellent	82.58	15.42
	Good	89.57	19.64
	Fair	85.79	19.74
	Poor	84.00	18.12
	Terminally ill (n=1)	104.00	-
<u>Religiosity</u>	Very religious	85.35	16.83
	Regular worshipper	87.00	19.33
	Occasional worshipper	93.15	23.46
	Not active	85.71	26.86
<u>Education</u>	Part Secondary Finished	84.33	19.16
	Secondary	92.40	18.84
	Part Tertiary Finished	98.00	19.95
	Tertiary	87.56	15.49

Table 3

Results of a One-way ANOVA of Total Euthanasia Attitude Scale and Biographical Variables

Demographic variable	df	F	p
Age	4	1.706	.153
Language	3	1.649	.182
Ethnic origin	2	1.180	.311
Academic background	3	1.545	.207
Marital status	4	1.280	.282
Religion	4	1.093	.364
Religiosity	3	0.637	.593
Health	4	0.835	.506

There is not much difference between the scores of each group within each demographic variable. Table 3 also indicates that there exist no statistical differences between any one of the variables and the attitude a person will have towards euthanasia.

The mean and standard deviation of the scores for the subjects of this study relating to euthanasia, as well as each individual scale are presented in Table 4.

Table 4

Frequency Distribution of Total Population Regarding the Euthanasia Attitude Scale (N = 120)

	x	SD
Total EAS	86.62	18.77
EAS: General orientation	36.97	10.83
EAS: Patient rights issues	23.01	6.57
EAS: Technology	16.67	4.10
EAS: Professional role	11.03	2.76
EAS: Values and ethics	11.81	3.80

Table 4 indicates the average score of the total population on the Euthanasia Attitude Scale, as well as on each individual scale, which in itself proves helpful if it is taken into account when looking at Table 4. Table 5 compares the means and standard deviations of those favouring euthanasia and those opposing euthanasia.

Table 5
Mean Differences on the Total Euthanasia Attitude Scale and Sub-Scales for People Favouring and Opposing Euthanasia

Scales		x	SD	df	t
Total EAS	Favour	103.00	10.78	118	-17.379**
	Oppose	71.29	9.19		
EAS: General Orientation	Favour	46.02	7.52	118	-15.101**
	Oppose	28.50	5.02		
EAS: Patient rights issues	Favour	27.67	4.42	118	-10.329**
	Oppose	18.65	5.10		
EAS: Technology	Favour	18.98	2.67	118	-7.138**
	Oppose	14.50	4.02		
EAS: Professional role	Favour	12.12	2.75	118	-4.501**
	Oppose	10.02	2.37		
EAS: Values and ethics	Favour	14.38	3.16	118	-9.449**
	Oppose	9.40	2.60		

** $p < 0.01$

Table 5 indicates that people who favour euthanasia have higher scores on the scale than those who oppose euthanasia. People opposing euthanasia consequently also had lower means on each of the five sub-scales. The differences between the two groups on the Euthanasia Attitude Scale and the sub-scales were significant ($p < 0.01$).

The mean score for the Purpose in Life Test was 102.53 (SD = 12.29). The results of the t-test on Purpose In Life between favouring and opposing Euthanasia can be seen in Table 6.

Table 6
Mean Differences on the Purpose In Life Test for People Favouring and Opposing Euthanasia

	x	SD	t	p
Favouring Euthanasia (n=58)	104.7414	12.7397		
Opposing Euthanasia (n=62)	100.4677	11.5726	-1.925	0.057

It can be seen that those in favour of euthanasia have a slightly higher score on the Purpose In Life test than those who oppose euthanasia, but the scores were not statistically significant. The results of the t-test suggest that the score of a person who favours euthanasia will not be significantly different from a person who opposes euthanasia.

Results of Pearson Coefficient correlation between the Euthanasia Attitude Scale, the Purpose In Life test and some Biographical Variables are seen in Table 7.

Table 7

Pearson Correlation Coefficient Between Euthanasia Attitude Scale, Purpose In Life Scores and Some Biographical Variables

	1	2	3	4	5	6	7	8	9	10
1	-									
2	0,085	-								
3	0,910**	0,024	-							
4	0,859**	0,106	0,711**	-						
5	0,657**	0,229*	0,383**	0,577**	-					
6	0,541**	-0,006	0,374**	0,423**	0,345**	-				
7	0,671**	0,029	0,736**	0,390**	0,248**	0,276**	-			
8	0,225*	-0,003	0,178	0,190*	0,167	0,279**	0,092	-		
9	0,117	0,225*	0,018	0,067	0,183*	0,208*	-0,011	0,109	-	
10	0,065	-0,065	0,113	-0,001	-0,048	0,072	0,204*	-0,076	-0,061	-

* $p < 0,05$

** $p < 0,01$

- Note:**
- 1 Euthanasia Attitude Scale (EAS) total
 - 2 Total Purpose in Life Scores
 - 3 EAS: General orientation
 - 4 EAS: Patient rights issues
 - 5 EAS: Technology
 - 6 EAS: Professional role
 - 7 EAS: Values and ethics
 - 8 Age
 - 9 Ethnic origin
 - 10 Religious belief

According to Table 7, there is a significant correlation between the Total Euthanasia Attitude Scale and the sub-scales: General Orientation, Patient Rights Issues,

Technology, Professional's Role, and Values and Ethics. Of the biographical variables age is the only variable that correlates significantly with the Total Euthanasia Attitude Scale, which show that the older a person becomes the more he or she will favour euthanasia. Ethnicity on the other hand, is the only biographical variable that correlates significantly with the Purpose In Life Tests, which indicate that people from different ethnic backgrounds have different meaning and purpose in life. Ethnicity also correlated significantly with the Euthanasia Attitude sub-scales of technology and professional role, suggesting that people from different ethnic backgrounds see the responsibilities from professionals and the use of technology differently. Age correlates significantly with the Euthanasia Attitude sub-scales of patient rights issues and professional role, whilst religion correlates significantly with the Euthanasia Attitude sub-scale of values and ethics – signifying that different values and ethics exists amongst different religious groups. Table 7 furthermore also show that the Euthanasia Attitude sub-scale of technology correlates significantly with the Purpose In Life Test, indicating that the higher a person's view of his or her purpose in life is, the more he or she will consider the usefulness of technology.

The frequency distribution of those favouring and opposing euthanasia according to age can be seen in Table 8.

Table 8

Frequency Distribution of those Favouring and Opposing Euthanasia According to Age

Age	Opposing	Favouring	Total
65-69	16	11	27
70-74	17	10	27
75-79	10	13	23
80-84	10	12	22
85+	9	12	21

Table 8 reports that the older the respondent, the more in favour he or she is of euthanasia.

Chapter 5

DISCUSSION AND RECOMMENDATIONS

5.1 Introduction

The aim of this study was to determine how older adults felt about euthanasia and if there was any difference in the views of individuals from different ethnic origins. The influence of meaning in a person's life and health status were also considered.

Because of limited research establishing the attitudes of older adults towards euthanasia, four variables were identified and studied, namely age, cultural background, meaning in life and health status. It would appear, despite research evidence to the contrary, that except for age, these variables did not noticeably predict a person's attitude towards euthanasia. There was, in fact, very little statistical significance between these variables and a person's attitude towards euthanasia.

5.2 Euthanasia Attitude Scale (EAS)

The EAS-scale measured the general attitude a person will have towards euthanasia and further focussed on five specific issues concerning euthanasia, namely a person's general orientation towards euthanasia, patient rights issues, influence of technology, the professional's role, and values and ethics. All five issues measured correlated highly with the Euthanasia Attitude Scale, thus supporting the extensive studies and findings regarding the test's validity and reliability done by Holloway et al. (1995).

5.3 Age

Research (Bachman et al., 1996; Blendon, 1992; Cicerelli, 1997; Rogers, 1996; Twycross, 1990) indicates that older adults are more negatively disposed towards euthanasia than the general population. There was, however, a positive correlation

between age and acceptance of euthanasia. The older the adult became the more acceptant of euthanasia he or she became.

A plausible explanation for the reversal in expected results for age in this study may be attributed to the fact that the subjects were all residents of homes for the aged. According to Billing (1987), the social system in which older adults find themselves is of vital importance in their attitude towards life.

Pearlman and Ryan-Dykes (1986) estimate that more than 50% of older adults who are residents in homes for the aged no longer function independently and rely on others for care and support. This dependency and the continuous exposure to the pain, suffering, illness and death of other residents, may cause older adults to view themselves as less in control of their own lives, environment and circumstances (Biggs, 1993; Heckhausen, 1999; Strümpher, 1992) and therefore more exposed to the mercy of others. This view is supported by Cicerelli (1997) and Gunasekera et al. (1986) who found that the elderly regard themselves as having little autonomy in health care matters. The older section of the subjects (75 years and older) would, according to this theory, be more exposed to the experience of pain and the deaths of others and would therefore be more in favour of euthanasia. For many residents an earlier death may also be a way out of the place which they often view as an institution.

5.4 Ethnicity

While Comaz-Diaz and Griffith (1988), Hessing et al. (1996) and Lee et al. (1996) argue that attitudes toward life and death are socio-culturally based, culturally specific, and influenced by a person's ethno-cultural identity, this study found no statistically significant differences in the opinions of people from different ethnic backgrounds.

Social reality in South Africa is such that few Africans are untouched by the pressures and demands caused by a shift away from traditional beliefs, values, social structures, customs and the influences of acculturation (Donald & Hlongwane, 1989). Urbanisation

and industrialisation have had a profound impact on family life amongst the different ethnic groups. Among European groups, it has led to the break-up of the traditional, extended family network and the emergence of the nuclear family system (McKendrick & Hoffman, 1990; Rautenbach, 1989). For the Coloured population urbanisation resulted in less stable family life. To some extent, this is also true of the African population (McKendrick & Hoffman, 1990).

According to Rautenbach (1989), an important characteristic of urbanisation is that the members of families become more isolated within their own nuclear families, which effect their interaction with the broader ethnic-social group. The extended family and broader ethnic group usually put norms and values in place (Rautenbach, 1989). However, urbanisation restricts the influence of the extended family, with the result that members of the specific ethnic groups receive less guidance on how to approach certain situations. Thus they are alienated from their extended family's morals and values (Rautenbach, 1989). Rautenbach (1989) illustrates this point by focussing on the change in the social, religious and legal structures of urbanised Africans, which is a direct product of the acculturation process. She explains that indigenous legal rules are pining, the hierarchy of authority is becoming less affective, parenting approaches are changing from authoritarian to more permissive, the extended family structure is replaced with the nucleus family – which results from a change in economic status - and the influence and importance of ancestral spirits are declining. According to Frankl (1967), Frankl (1980) and Havenga (1974), these fading forces of religion, traditional morality and values result in people falling prey to conformity and lead to the disappearance of definite differences between different ethnic groups. Furthermore, the political transformation process in South Africa has lead to the amalgamation of cultures, resulting in the loss of cultural identity and uniqueness.

5.5 Meaning in Life

Meaning in life, which enables a person to predict and control his environment, including the social environment of relationships with other people (Baumeister, 1991), was

measured by Crumbaugh and Maholick's (1969) Purpose in Life (PIL) test. This test is based on Frankl's philosophy of finding meaning in life.

Although Table 6 indicates that those in favour of euthanasia had slightly higher scores on the PIL test than those opposed to euthanasia, meaning was in general found not to have a significant influence on a person's view towards euthanasia. This insignificance may be explained by developmental psychology. According to the disengagement theory, (Lefrançois, 1999) people progressively disengage as they get older by withdrawing from social, physical, and emotional interaction with the world. According to Frankl (1960) this unresponsiveness and inexperience can contribute towards a person's lack of meaning in life.

According to Baumeister (1991), culture presents the individual with a broad context in which life may be given meaning. South Africa is a multi-cultural society that offers multiple ideologies and the wide range of beliefs and values from which an elderly person have to choose meaning could be bewildering and may result in life being experienced as meaningless. Frankl (1967; 1980) describes this meaninglessness as an existential vacuum.

According to Frankl (1967; 1980) the declining force of religion, traditional morality and tradition itself have resulted in the disappearance of many cultural values. As a consequence communities are left with a serious value gap. A lack or loss of meaning is often central to suffering and unhappiness (Baumeister, 1991). This argument can offer a possible explanation why the respondents of this sample were neither for nor against euthanasia.

5.6 Health status

Although ill people have been shown to be more approving of euthanasia than people with little or no serious health problems (Dacey & Travers, 1994; Larue, 1996), poor health failed to relate significantly to euthanasia. A possible explanation for this could be

that elderly persons with certain personality types may be predisposed to develop psychological disorders when the magnitude and rapidity of poor health, external stress and loss increase, especially when compensatory, external sources of support are not available (Lazarus, 1987). The social system in which older adults find themselves – homes for the aged - is of vital importance in assessing their view on their own health and the vulnerability to psychological problems, and to depression in particular (Billing, 1987).

Lazarus (1987) writes that, although personality styles and traits do not appear to change with age, there does appear to be a shift of focus in the ageing adult's inner life. This is reflected in the older person's view of himself in relation to the environment, in his or her preoccupations and values and, to some extent, in the type of internal coping mechanisms used by the person.

Since all of the respondents were in homes for the aged, none of them had complete privacy and they functioned almost entirely within an aged group context. Their views with regards to euthanasia reflected the attitude of many elderly people (as discussed previously) who do not take responsibility for decisions regarding health and end-of-life matters.

5.7 Conclusion

While the results of this particular study failed to prove that culture, meaning in life and pain have a significant effect on a person's views regarding euthanasia, the literature available on the subject indicates the opposite. This area therefore deserves further study.

One of the questions that ought to be raised, is how the present situation in South Africa, which is characterised by apathy with regards to human life and poor health care for the elderly, will influence the outlook of the elderly towards euthanasia. The phenomenon of acculturation and culture amalgamation and how it will affect a person's outlook on end-of-life decisions must also be investigated.

What this study achieved was to prove that issues relating to end-of-life decisions are extremely personal and unpredictable. It cannot be assumed that the older a person becomes the more he or she will conform to religious dogmas and outlooks which condemn euthanasia. Furthermore, older adults' opinions cannot randomly be assumed to conform to that of the younger adult population. Health psychologists and counselling professionals should therefore be even more sensitive to each person's motivation and reasoning behind his or her end-of-life decision.

5.8 Recommendations

Future research should involve a larger sample – preferably the entire country - and should encompass adults from all age groups and all residential backgrounds. Research should also attempt to include subjects from both the rural and urban areas, since rural communities may still be more traditional in their outlook and experience with regard to end-of-life decisions (Donald & Hlongwane, 1989). Subjects from other ethnic groups (other than Xhosa, European and Coloured) should also be studied, since different groups have different morals and values concerning life and dying. Future studies should also focus on the influence of the existence or absence of health care and medical aid, as well as the influence of autonomy on each respondent's view on euthanasia.

Koenig (1993) and Cicerelli (1997) argue that more research needs to be done on the attitudes of healthy and chronically or terminally ill elderly people toward euthanasia. Anderson and Cadell (1993), however, are of the opinion that research amongst less and more industrialised countries is more important and that there exists a need to see how industrialisation influences acceptance of euthanasia.

A definite need exists for future studies relating to the Aids pandemic and its influence on the view that it is acceptable for people to shorten their lives to escape intolerable pain.

Questions regarding the ethics surrounding medical decisions to end life will always be part of our society, not only because medical advances develop at an incredible pace, but also because human beings increasingly want to be in control of their environment and their lives. It is therefore of the utmost importance that research in the field of end-of-life decisions is increasingly undertaken.

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ADDENDUM A

Biographic Questionnaire

Circle the most appropriate answer:

1. Sex: M/F
2. Age:
 1. 65-69
 2. 70-74
 3. 75-79
 4. 80-84
 5. 85+
3. Language:
 1. Afrikaans
 2. English
 3. Xhosa
 4. Other
4. Ethnic Origin:
 1. African
 2. Coloured
 3. European
5. Academic Background:
 1. Finished part of Secondary Education
 2. Finished Secondary Education
 3. Finished part of Tertiary Education
 4. Finished Tertiary Education
6. Marital Status:
 1. Married
 2. Widowed
 3. Divorced
 4. Separated
 5. Never married

7. Religious Belief:

1. Roman Catholic
2. Protestant
3. Jew
4. Muslim
5. Buddhist
6. African (e.g. Sionism)
7. Other
8. Agnostic
9. Atheist

8. Level of Religious Activity:

1. Very religious
2. Regular worshipper
3. Occasional worshipper
4. Not active

9. How often do you attend a religious meeting:

1. Once a year
2. Twice a year
3. More than twice a year
4. Once a month
5. Twice a month
6. Once a week
7. More than once a week

10. Health:

1. Excellent
2. Good
3. Fair
4. Poor
5. Terminally ill

11. Has your health interfered with your normal daily routine over the past three months?

1. Not at all.
2. Not very often.
3. Some of the time.
4. Most of the time.

12. Have you ever suffered such unbearable pain that you felt you could not cope?

1. Yes
2. No

Biografiese Vraelys:

Omkring die mees gepaste antwoord:

- | | |
|--------------------------|--|
| 1. Geslag | M/V |
| 2. Ouderdom | 1. 65-69
2. 70-74
3. 75-79
4. 80-84
5. 85+ |
| 3. Taal | 1. Afrikaans
2. Engels
3. Xhosa
4. Ander |
| 4. Etniese oorsprong | 1. Afrikaan
2. Kleurling
3. Europeër |
| 5. Akademiese agtergrond | 1. Gedeelte van Sekondêre opleiding
2. Voltooi sekondêre opleiding
3. Gedeelte van Tersiêre opleiding
4. Voltooi Tersiêre opleiding |
| 6. Huwelikstatus | 1. Getroud
2. Weduwee/Wewenaar
3. Geskei
4. Vervreemd
5. Ongetroud |

7. Geloof
1. Rooms-Katoliek
 2. Protestant
 3. Joods
 4. Moslem
 5. Boeddhis
 6. Afrika-kerk (bv. Sionis)
 7. Ander
 8. Agnostiek
 9. Ateïs
8. Graad van geloofsbeoefening
1. Baie gelowig
 2. Gereelde aanbidder
 3. Geleentheidsaanbidder
 4. Nie aktief
9. Hoe gereeld woon u geloofsbyeenkomste by
1. Een maal per jaar
 2. Twee maal per jaar
 3. Meer as twee maal per jaar
 4. Een maal per maand
 5. Twee maal per maand
 6. Een maal per week
 7. Meer as een maal per week
10. Gesondheid
1. Uitstekend
 2. Goed
 3. Gemiddeld
 4. Sleg
 5. Terminaal siek

11. Het u gesondheid met u normale daaglikse roetine ingemeng die afgelope drie maande?

1. Glad nie
2. Nie gereeld nie
3. Soms
4. Meestal

12. Het u al ooit sulke ondraaglike pyn ervaar dat u voel u kan dit nie meer hanteer nie?

1. Ja
2. Nee

ADDENDUM B

Euthanasia Attitude Scale

The following items are designed to measure the attitudes of persons toward the practice of what is usually called “euthanasia”. We are defining euthanasia 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 five responses (where 1 = strongly agree and 5 = strongly disagree) what most closely represents your own attitude toward the statement content.

-
1. Even if death is positively preferable to life in the judgement of a terminal patient, no action should be taken to induce the patient’s death.
1 2 3 4 5
 2. Under any circumstances I believe that physicians should try to prolong the lives of their patients.
1 2 3 4 5
 3. To me there is absolutely no justification for ending the lives of persons even though they are terminally ill.
5 4 3 2 1
 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 5
 5. I believe it is more humane to take the life of an individual who is terminally ill and in severe pain than to allow him/her to suffer.
1 2 3 4 5
 6. An individual who is “brain dead” should be kept alive with proper medical intervention.
5 4 3 2 1

7. I believe that a person with a terminal and painful disease should have the right to refuse life sustaining treatment.
1 2 3 4 5
8. I bear no ill feelings toward a person who hasten the death of a loved one to spare the loved one further unbearable physical pain.
1 2 3 4 5
9. I believe there should be legal avenues by which an individual could pre-authorise his/her own death in case intolerable illnesses arise.
1 2 3 4 5
10. I cannot envision any medical circumstance in which the termination of life would be merciful.
1 2 3 4 5
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.
5 4 3 2 1
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 5
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.
1 2 3 4 5
14. If I were faced with the prospect of having a loved one suffer a slow and painful death, I would support his/her decision to refuse medical life sustaining treatment.
1 2 3 4 5
15. To me it is an act of mercy to a living but "brain dead" person to turn off the life sustaining machines.
1 2 3 4 5
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.
1 2 3 4 5
17. It is cruel to prolong intense suffering for someone who is mortally ill and desires to die.
5 4 3 2 1

18. No one, including medical professionals, should be allowed to decide to end a suffering person's life.
1 2 3 4 5
19. To me, anyone who assists a suffering and terminally ill person to die is nothing but a common murderer.
1 2 3 4 5
20. A terminally ill person who is in severe pain deserves the right to have his/her life ended in the easiest way possible.
1 2 3 4 5
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 ignore his plea.
5 4 3 2 1
22. The injection of a lethal dose of some drug to a person in order to prevent that person from dying an unbearably painful death is unethically.
1 2 3 4 5
23. No matter how much a person might plead for death to avoid unbearable pain, no one should assist the person to accomplish his/her wish.
1 2 3 4 5
24. Inducing death for merciful reasons is acceptable.
1 2 3 4 5
25. Terminally ill patients who try to starve themselves to death to avoid unbearable pain should be forcefully fed intravenously.
5 4 3 2 1
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 5
27. The termination of a person's life, done as an act of mercy, is unacceptable to me.
1 2 3 4 5
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 5
29. One should have the right to choose to die if he/she is terminally ill and is suffering.
5 4 3 2 1

30. A terminally ill individual should be allowed to reject life support systems.

1 2 3 4 5

Genadedoodhoudingskaal

Die volgende vrae is saamgestel om die houdings van persone teenoor die praktyk van “genadedood” te meet. Ons definieer 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 hopeloos beseer is, kan verleng, met die doel om genade te betoon.

Lees elke stelling noukeurig, kies die een uit die vyf reaksies (waar 1 = stem beslis saam en 5 = stem glad nie saam nie) wat u houding teenoor die stellinginhoud die beste verteenwoordig.

-
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 te weeg te bring nie.
1 2 3 4 5
 2. Ek glo dat doktors onder alle omstandighede moet poog om die lewens van hulle pasiënt te verleng, ongeag die omstandighede.
1 2 3 4 5
 3. Daar is volgens my absoluut geen regverdiging vir die beëindiging van menselewens nie, selfs nie al is hulle terminaal siek nie.
5 4 3 2 1
 4. Sommige pasiënte “word slegs gemaklik gemaak” (byvoorbeeld, ontvang pynverliggende 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 5
 5. Ek glo dit is mensliker om iemand wat terminaal siek is en erge pyn ly se lewe te neem as om toe te laat dat hy/sy ly.
1 2 3 4 5
 6. ‘n Persoon wat “breindood” is, behoort lewend gehou te word deur toepaslike mediese ingryping.
5 4 3 2 1
 7. Ek glo dat ‘n persoon met ‘n terminale en pynvolle siekte die reg behoort te hê om lewensonderhoudende behandeling te weier.
1 2 3 4 5
 8. Ek het geen kwaai gevoelens teenoor ‘n persoon wat die dood van ‘n geliefde bespoedig ten einde die geliefde verdere ondraaglike fisiese pyn te spaar nie.
1 2 3 4 5

9. Ek glo daar behoort wetlike kanale te wees waarvolgens 'n persoon vooraf magtiging kan gee vir sy/haar dood in geval van ondraaglike siekte.
1 2 3 4 5
10. Ek kan my nie enige mediese omstandigheid voorstel waar die beëindiging van lewe genadig sal wees nie.
1 2 3 4 5
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.
5 4 3 2 1
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 5
13. Ek ondersteun die besluit om 'n terminaal siek persoon wat sterwend is en slegs enkele ure oor het om te lewe "slegs gemaklik te maak".
1 2 3 4 5
14. Sou 'n situasie ontstaan waar ek 'n geliefde 'n stadige en pynvolle dood moes sien sterf, sou ek sy/haar besluit om lewensonderhoudende medikasie te weier, ondersteun.
1 2 3 4 5
15. Vir my is dit 'n gebaar van genade om die lewensonderhoudende masjiene af te skakel van 'n lewende, maar breindood persoon.
1 2 3 4 5
16. As ek 'n stadige, pynvolle dood moes sterf, sou ek die keuse wou he om my eie lewe te beëindig in die vinnigste en maklikste manier moontlik.
1 2 3 4 5
17. Dit is wreed om intense lyding van 'n persoon wat terminaal is en vra om te sterf, te laat voortsloer.
5 4 3 2 1
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 5
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 5
20. 'n Terminaal siek persoon wat in baie pyn is, behoort die reg te he om te besluit om sy/haar lewe op die maklikste manier moontlik te beëindig.
1 2 3 4 5
21. Sou 'n vriende wat erge pyn ly en naby sterwe is, my smeek om die dokters te oortuig om sy/haar lewe op 'n genadige manier te beëindig, sou ek hom/haar ignoreer.
5 4 3 2 1

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 5
23. Maak nie saak hoe baie 'n persoon pleit om vroeer te sterf om ondraagbare pyn te voorkom nie, niemand behoort die persoon bystaan en te help om sy/haar wens uit te voer nie.
1 2 3 4 5
24. Om die dood te versnel vir genade is aanvaarbaar.
1 2 3 4 5
25. Terminaal siek pasiente wat hulself uithonger te einde die ondraagbare pyn van die dood te voorkom, moet met mag binne-aars gevoed word.
5 4 3 2 1
26. Ek beskou dit oneties om toe te laat dat menslike lewe beeindig word waar mediese tegnologie dit kan onderhou.
1 2 3 4 5
27. Ek beskou die beeindiging van 'n persoon se lewe, selfs al is dit uit genade, as onaanvaarbaar.
1 2 3 4 5
28. Volgens my is dit moord om iemand te help om sy lewe te beeindig, al staar die persoon ondraagbare pyn in die gesig.
1 2 3 4 5
29. 'n Persoon behoort die reg te he om te besluit om sy/haar lewe te beeindig indien hy/sy terminaal siek is en ly.
5 4 3 2 1
30. 'n Terminaal siek persoon behoort die reg te he om pogings om sy/haar lewe te onderhou van die hand te wys.
1 2 3 4 5

ADDENDUM C

The Purpose In Life Test

Choose the best answer, which is according to you the closest to the truth. You will notice that the numbers vary from one extreme emotional statement to the other. Neutral indicates that you are not convinced of either one of the options and therefore do not want to choose. Try and use this option as little as possible.

1. I am usually:

Extremely bored

Enthusiastic, full of life

1 2 3 4 5 6 7

Neutral

2. For me life is:

Always exciting

Throughout routine

7 6 5 4 3 2 1

Neutral

3. In life I have:

No goals or prospects

Clear goals and prospects

1 2 3 4 5 6 7

Neutral

4. My personal existence:

Utterly meaningless
without any purpose

Very purpose- and
meaningful

1 2 3 4 5 6 7

Neutral

5. Every day is:

Always exciting and different

Tedious

7 6 5 4 3 2 1

Neutral

6. If I could choose I would:

Prefer not to
be born

Like to live my life
over again and again

1 2 3 4 5 6 7

Neutral

7. After I retire, I would:

Like to do all the things
that I always wanted to do

Only laze

7 6 5 4 3 2 1

Neutral

8. In the actualisation of my life goals:

I have made absolutely
no progress

I was extremely
successful

1 2 3 4 5 6 7

Neutral

9. My life is:

Empty and full
of despair

Filled with exciting
and purposeful things

1 2 3 4 5 6 7

Neutral

10. If I die today, I will feel that my life:

Was very meaningful

Was totally meaningless

7 6 5 4 3 2 1

Neutral

11. When I think about my life:

I often wonder
why I exists

I always see a reason
to justify my existence

1 2 3 4 5 6 7

Neutral

12. When I interpret the world according to my own life, the world is:

Extremely confusing

In harmony with my own life

1 2 3 4 5 6 7

Neutral

13. I am an:

Extremely irresponsible
person

Extremely responsible
person

1 2 3 4 5 6 7

Neutral

14. Regarding a person's freedom of choice, I think that people:

Are totally free to
make their own
decisions about life

Completely tied up by the
influences of heredity and
environment

7 6 5 4 3 2 1

Neutral

15. About death, I feel:

Prepared and not
afraid

Unprepared and
frightened

7 6 5 4 3 2 1

Neutral

16. About suicide, I have:

Seriously considered it
as a solution

Never even
gave it a thought

1 2 3 4 5 6 7

Neutral

17. I see my potential to find meaning, purpose and calling in life as:

Very attainable

Very unattainable

7 6 5 4 3 2 1

Neutral

18. My life is:

In my own hands and
I am in full control

Not in my own hands and
controlled by external factors

7 6 5 4 3 2 1

Neutral

19. When I gaze at my daily work, it is a:

Source of pleasure
and satisfaction

Painful and boring
experience

7 6 5 4 3 2 1

Neutral

20. I have discovered that I:

Have no calling or
purpose in life

Clear objectives and a
satisfying meaning in life

1

2

3

4

5

6

7

Neutral

Doel-in-die-lewe-vraelys

Kies die beste antwoord, wat volgens u die naaste aan die waarheid is.. U sal oplet dat die keuses van een ekstremititeit na 'n volgende op 'n kontinuum geplaas is, met neutraal in die middel. Neutraal sal aandui dat u nie seker is oor 'n antwoord nie, maar probeer asseblief om laasgenoemde so min as moontlik te gebruik.

1. Ek is gewoonlik:

Uiters verveeld

Entoesiasies, lewenslustig

1	2	3	4	5	6	7
Neutraal						

2. Die lewe is vir my:

Altyd opwindend

Deurgaans geroutineerd

7	6	5	4	3	2	1
Neutraal						

3. In die lewe het ek:

Geen doelstellings of
vooruitsigte nie

Duidelike doelstellings
en vooruitsigte

1	2	3	4	5	6	7
Neutraal						

4. My persoonlike bestaan is:

Uiters betekenisloos,
sonder enige doel

Uiters sinvol en
betekenisvol

1 2 3 4 5 6 7

Neutraal

5. Elke dag is:

Deurgaans opwindend en anders

Eentonig

7 6 5 4 3 2 1

Neutraal

6. As ek kon kies sou ek:

Liewers nie gebore
wou wees nie

Graag my lewe 'n paar
keer weer wil lewe

1 2 3 4 5 6 7

Neutraal

7. Nadat ek afgetree het, sou ek graag:

Die opwindende dinge doen,
wat ek nog altyd wou

Slegs leeglê

7 6 5 4 3 2 1

Neutraal

8. In die verwesenliking van my lewensdoelstellings:

Het ek absoluut geen
vordering gemaak nie

Was ek uiters
suksesvol

1 2 3 4 5 6 7

Neutraal

9. My lewe is:

Leeg en vol van
wanhoop

Gevul met opwindende
sinvolle dinge

1 2 3 4 5 6 7

Neutraal

10. As ek vandag sou sterwe, sou ek voel dat my lewe:

Baie betekenisvol was

Heeltemal sinloos was

7 6 5 4 3 2 1

Neutraal

11. As ek aan my lewe dink:

Wonder ek dikwels
hoekom ek bestaan

Sien ek altyd 'n rede
wat my bestaan regverdig

1 2 3 4 5 6 7

Neutraal

12. As ek die wêreld in terme van my eie lewe interpreteer, is die wêreld:

Uiters verwarrend

In harmonie met my eie lewe

1 2 3 4 5 6 7

Neutraal

13. Ek is 'n:

Uiters onverantwoordelike
persoon

Uiters verantwoordelike
persoon

1 2 3 4 5 6 7

Neutraal

14. Rakende die mens se vryheid om eie keuses te maak, dink ek dat die mens:

Absoluut vry is om
sy eie lewenskeuses
te maak

Volkome gebind is deur
invloede van oorerwing
en die omgewing

7 6 5 4 3 2 1

Neutraal

15. Ten opsigte van die dood is ek:

Voorbereid en nie bang nie

Onvoorbereid en bang

7 6 5 4 3 2 1

Neutraal

16. Ten opsigte van selfmoord het ek:

Dit al ernstig oorweeg
as 'n oplossing

Dit nog nooit eers 'n
gedagte gegee nie

1 2 3 4 5 6 7

Neutraal

17. Ek sien my eie moontlikheid om doel of roeping in die lewe te vind as:

Uiters haalbaar

Uiters skraal

7 6 5 4 3 2 1

Neutraal

18. My lewe is:

In my eie hande en ek
is ten volle in beheer

Nie in my eie hande nie
en word deur eksterne
faktore beheer

7 6 5 4 3 2 1

Neutraal

19. As ek my daaglik werk in die gesig staar, is dit vir my 'n:

'n Bron van plesier
en bevrediging

Pynvolle en vervelende
ervaring

7 6 5 4 3 2 1

Neutraal

20. Ek het ontdek dat ek:

Geen roeping of doel
in die lewe het nie

Duidelike doelstellings
en bevredigende
betekenis in die lewe
het

1 2 3 4 5 6 7

Neutraal

ADDENDUM D

ARCHDIOCESE of CAPE TOWN

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May 20, 2000

Mr Nico Nortje

Dear Mr Nortje

I have received your letter dated May 11 asking for the teaching of the Catholic Church regarding Euthanasia and Suicide.

Regarding Euthanasia, the latest Catechism of the Catholic Church has this to say:

“ 2276 Those whose lives are diminished or weakened deserve special respect. Sick or handicapped persons should be helped to lead lives as normal as possible.

2277 Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick or dying persons. It is morally unacceptable.

Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator. The error of judgement into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded.

2278 Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of "over-zealous" treatment. Here one does not will to cause death; one's inability to impede it is merely accepted. The decisions should be made by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, whose reasonable will and legitimate interests must always be respected.

2279 Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted. The use of painkillers to alleviate the sufferings of the dying, even at the risk of shortening their days, can be morally in conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable. Palliative care is a special form of disinterested charity. As such it should be encouraged.

2324 Intentional euthanasia, whatever its forms or motives, is murder. It is gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator.”

Thus (my own words) the Church does distinguish between active and passive Euthanasia. In general active Euthanasia is not permitted, while passive Euthanasia is. As you will notice, the intention of the person performing the action is considered to be of great importance.

Regarding Suicide, the Catechism says this:

“ 2280 Everyone is responsible for his life before God who has given it to him. It is God who remains the sovereign Master of life. We are obliged to accept life gratefully and preserve it for his honour and the salvation of our souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of.

2281 Suicide contradicts the natural inclination of the human being to preserve and perpetuate his life. It is gravely contrary to the just love of self. It likewise offends love of neighbour because it unjustly breaks the ties of solidarity with family, nation and other human societies to which we continue to have obligations. Suicide is contrary to love for the living God.

2282 If suicide is committed with the intention of setting an example, especially to the young, it also takes on the gravity of scandal. Voluntary co-operation in suicide is contrary to the moral law.

Grave psychological disturbances, anguish or grave fear of hardship, suffering or torture can diminish the responsibility of the one committing suicide.

2283 We should not despair of the eternal salvation of persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives.

2325 Suicide is seriously contrary to justice, hope and charity. It is forbidden by the fifth commandment.”

May I add something on what could be called “indirect suicide” – ie doing something which has an intentionally good effect, but from which death also follows. Thus eg it would be permissible to leap from a burning height to escape burning to death – especially if there is some hope of escaping from death from the fall.

This "Catechism of the Catholic Church" was published in October 1992 in the form of an "Apostolic Constitution" by Pope John Paul II, and is quite the latest and official teaching of the catholic Church. I would suppose that you could take what is said in the Catechism as being a supplement to the 1057 and 1980 documents which you quote in your letter to me. However, officially the Catechism was published as a "follow up" of the Second Vatican Council.

I do hope I have helped with this response. If you have any further queries, do not hesitate to contact me.

With my very best wishes

A handwritten signature in black ink, consisting of a cursive name followed by a plus sign and the name 'R. Cawcutt'.

✠ REGINALD CAWCUTT

Auxiliary Bishop

ADDENDUM E



UNIVERSITEIT VAN STELLENBOSCH
UNIVERSITY OF STELLENBOSCH

Dear Sir/Madam

The debate regarding end-of-life decisions and its place in modern society has become quite extensive over the past few years, especially in the light of the proposed changes to South African legislation on euthanasia in favour of voluntary euthanasia. Although the subject of euthanasia has been widely studied, not much attention has yet been paid to the views of the older population on the subject, specifically in South Africa.

Nine comma six percent (9.6%) of the South African population are now older than 65 years of age. Research conducted in The Netherlands has shown that 79% of all recorded deaths involved older, medically ill people. Taking into account these figures, the proposed change in euthanasia legislation and arguments debating the autonomy of a person, it is clearly important to study the attitudes of older adults towards euthanasia.

I fully understand the personal and sensitive nature of some of the questions and assure you that your responses will remain completely anonymous and confidential. However, for participation in this study, as well as for ethical and professional reasons, you are required to sign this form, indicating that you fully understand the voluntary nature of this study and that you consent to participating in it.

Kind regards

A handwritten signature in black ink, appearing to read 'Nico Nortje', enclosed in a simple oval scribble.

Nico Nortje
(B.Soc.Sc; B.Soc.Sc. Hons. (Psyc))

Name

Signature