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HEALTH SOCIOLOGY REVIEW

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CONTRIBUTIONS

Authors preparing manuscripts for submission are requested to read the Author Guidelines on the inside back cover of the journal or the journal website. Proposals for special issues may be sent directly to the Editor: Fran Collyer, email: fran.collyer@arts.usyd.edu.au

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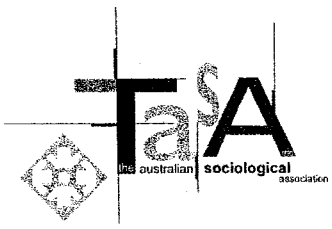

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 Health Sociology Review (2007) 16: 3–4

EDITORIAL

As this edition goes to press, a rather more important event (in the grand scheme of history) is taking place: the legislative approval of the ownership of private property in China. Given that it *is* a Friday evening, the building quiet, the editor all but deserted by her comrades; it is not difficult to hear the small sounds of Karl and Frederich struggling within their dark and lonely graves as they too hear the news. Reflecting, with furrowed brow, on this historic moment, I am rather abashed to admit we have no articles in this edition about health care in China. Nevertheless, I am comforted a little by the thought that readers may look back to past issues of *Health Sociology Review* where privatisation in China has been featured prominently.

In this edition there is much to offer the reader about the health care context or service systems of many other countries. Papers have made their way to my Sydney office across the intangibility of cyberspace from places as distant as Canada, Singapore, Trinidad, and France; and as close as Queensland, South Australia, northern New South Wales, the Australian Capital Territory and Tasmania. Three major themes have, somewhat serendipitously, emerged in our selection of papers: the challenges and opportunities faced by medicine from an ageing population; the impact on well-being of continuing social stigma; and the analysis of new trends and processes within the organisation of medicine and service delivery.

The papers of Alex Dumas and Bryan Turner, Joanna Sikora and Frank Lewins, address this first theme. Both focus on the ethical implications of new and older technologies which might lengthen or shorten an individual's life. For Dumas and Turner, the capacity to extend human life, perhaps indefinitely, raises concerns about the possibility of simultaneously increasing social inequality. For Sikora and Lewins, community condemnation of some forms of euthanasia indicate a more optimistic future (or at least not a more pessimistic one), in which an individual human life continues to have meaning.

The second theme emerges first in the paper from David Plummer and Pol McCann. In this exploration of the relationship between homophobia and heterosexuality, we are confronted with the darker side of our school playgrounds and schools: the construction of gender through processes of stigmatisation, exclusion, violence and harassment. The theme of stigmatisation and 'deviance' is also addressed in the paper by Peretti-Watel, François Beck, Stephane Legleye, and Jean-Paul Moatti. Here Becker's concept of a 'moral career' is applied to smoking behaviour among adolescents in France.

Our third theme, changes in the organisation of medicine and the delivery of health services, is taken up within three papers. Judy Singer and Kate Fisher analyse the debate about whether the apparent acceptance of non-orthodox medicines within medical clinics is the basis of a new partnership or merely an astute business practice on the part of

organised, institutional medicine. Kellie Brandenburg explores the nature of a new medical technology – pre-implantation genetic diagnosis – suggesting ideas for future research. Jane Jones takes on the corporate giants operating in the Australian health care market, demonstrating which of their strategies are financially more prudent for the company's themselves. The significance of this analysis is demonstrated when Jones argues that ownership arrangements for components of the health care market (such as diagnostic laboratories and medical centres), have significant implications for how the Medicare dollar is spent and what proportion of the national health budget will end up as corporate profit.

We trust you will appreciate the range and quality of the papers from this issue. As always I wish to thank our editorial team, publishers, reviewers, authors and *The Australian Sociological Association* for making the issue possible. A special thank you is due to my colleague and friend Toni Schofield. Toni and I were invited to co-edit *Health Sociology Review* in 2003, a challenge we have faced together for the past three years. This year Toni has decided to focus her energies elsewhere, and declined to continue as co-editor. We wish you well Toni, and thank you for all the energy, enthusiasm and imagination you have invested in the *Health Sociology Review*.

Fran Collyer
Editor in Chief
Health Sociology Review

 Health Sociology Review (2007) 16: 68–78

Attitudes concerning euthanasia: Australia at the turn of the 21st Century

With rapid developments in life-prolonging technologies and increases in average life expectancy, euthanasia has become an increasingly topical issue. This paper contributes to the euthanasia debate an analysis of Australian attitudes to assisted suicide, active non-voluntary as well as passive non-voluntary euthanasia. Between 1993 and 2002, Australians supported access to voluntary euthanasia of the terminally ill, but had reservations when death was not imminent. The age of patients was relatively unimportant in these considerations. Non-voluntary euthanasia of babies and adults received widespread approval only when particular situations could be defined as 'letting die' rather than 'killing'.

KEY WORDS

Sociology, attitudes to euthanasia – Australia, public opinion – Australia, survey studies of attitudes, assisted suicide, mercy killing

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Introduction

The recent bitter and anguished debate over the fate of Terry Schiavo, the US woman who spent years in a coma, is but one example of the consternation surrounding the issue of euthanasia. Such debates raise the question of whether death should be a choice and, if so, for whom and under what circumstances? Even before the Schiavo debate, life prolonging technologies, substantial increases in average life expectancy and activists' efforts have gradually made more transparent, public, and legitimate, a practice which had previously been less visible (Riley 1983:192-193). Some recent examples include Lesley Martin's admission of the 'mercy killing' of her terminally ill mother in New Zealand, the suicide of Australia's Nancy Crick (committed in the belief she had cancer, see *Daily Telegraph* 2004; Paget 2004) and the pro-choice campaign of the Australian euthanasia activist, Dr Phillip Nitschke, who publicises the 'Peaceful Pill' (King 2004).

Euthanasia: Conceptual complexities

The complex nature of situations in which acts of euthanasia occur necessitates an analytical approach involving varying degrees of human agency and intent. Therefore, we compare and contrast moral evaluations of active, passive as well as voluntary and non-voluntary euthanasia, which reflect the different levels of a patient's agency or autonomy (Lewins 1996:113-114).

In common discourse, the distinction between active and passive euthanasia is often reduced to a difference between 'killing' and 'letting die'. Voluntary euthanasia is a consensual act of an individual, in full awareness of the nature and likely consequences of their action. Although voluntary euthanasia is not always considered

synonymous with assisted suicide (Dworkin *et al.* 1998), we treat these two concepts as equivalent for the purpose of this analysis, due to the nature of our data. Involuntary euthanasia refers to situations when life is ended against the person's will which are outside the scope of this article. However, we describe attitudes concerning non-voluntary euthanasia, which may be considered in cases involving newborn babies with serious medical conditions, individuals experiencing severe dementia or senility, and unconscious patients. It is this type of situation, where it is debatable whether the wishes of the person are known or knowable, that is most likely to present significant ethical problems.

Differences in perceived proscriptions from acts of euthanasia and the tension between supporters and opponents of the decriminalisation of voluntary euthanasia have spawned an extensive literature in moral philosophy, law, bioethics and sociology. Most of this literature belongs in applied ethics; only a small part addresses public opinion, which calls for an explanation of the purpose and value of attitudinal studies in this area.

Policy and public opinion concerning euthanasia

Studies stemming from democratic theory consistently find that public opinion is salient in policy development in Western industrialised countries (Brooks and Manza 2006; Burstein 1998, 2003, 2006). The public, however, is more likely to form meaningful opinions about some issues than others, and thus the influence of attitudes varies in particular areas of policy. Attitudinal studies concerning euthanasia, which is an issue usually somewhat marginalised in the political discourse, lead to a better understanding of the social contexts in which euthanasia may become politically salient. The contrast between the dynamics of public opinion and actual policy implementation is likely to reveal the extent to which the regulation of the social practice involving end-of-life decisions reflects attitudinal changes (Burstein 2003). Identifying the structure and trends in attitudes to euthanasia, which we undertake in this article, is a preliminary step in this process. Our account extends and complements earlier survey-based analyses of public perceptions regarding euthanasia in Australia (Kuhse 1995; Hassan 1996; Kuhse *et al.* 1997).

Attitudinal analyses may also provide insights into personal preferences, although attitudes are known to be sometimes only weakly related to behaviour. Nevertheless, they demarcate the boundaries of individual choices which are not formed in a social vacuum (Hakim 2003:342). It is plausible, therefore, to expect some correspondence between general attitudes and individual behaviour in particular circumstances. As well as having the potential to shape the outcome of debates defining euthanasia's morality and legitimacy (Sawyer 1982), attitudes affect 'the framing process that structures any choice situation' (Bamberg *et al.* 1999:6). Policy analyses, therefore, which pay attention to public opinion offer more sophisticated and comprehensive explanations of policy directions and its long-term success (Burstein 1998).

Contextualising attitudes to euthanasia

The ethical discussion of euthanasia is too broad to be presented in detail here. Instead we turn to certain dominant themes, contrasting three, which vary in their predictions of why individuals hold particular attitudes towards end-of-life decisions (Table 1).

Utilitarian arguments necessitate comparisons of the amount of 'good' generated by alternative actions. Considering euthanasia, a utilitarian would weigh the perceived quality of life, against the suffering and the potential benefit of prolonging life or terminating it, for the individual or the society, including the family and community. Thus a patient's age, the nature of illness and his/her chances for recovery would all be taken into account and weighed to arrive at a moral proscription maximising welfare. If the public build their moral judgments about euthanasia on utilitarian grounds, we would expect little difference between approval of euthanasia by lethal injections and by withdrawal of treatment as they lead to the same outcomes

Table 1: Predictions and analysis results concerning support for different types of euthanasia

	Panel A.Utilitarianism or Consequentialism	Panel B.Christian doctrine	Panel C.Individualism based on deductive and rational principles	Results of our analysis
Active voluntary				
The terminally ill in pain	Approve. It will reduce prolonged pointless suffering	Reject. Humans have no autonomy to decide about their own lives, unless the primary goal is to 'reduce suffering' (i.e. double effect)	Approve if autonomous and rational choice	Moderately strong approval
The elderly	Approve only if the wish is sound and there is little chance for improving the quality of life by better integration into the community	Reject. Humans have no autonomy to decide about their own lives. There is no imminent death involved	Approve if autonomous and rational choice	Views equally divided between support and opposition
Young disabled adult	Approve only if the wish is sound and there is little chance for improving the quality of life by better integration into the community	Reject	Approve if autonomous and rational choice	Views equally divided between support and opposition
Young incurably ill adult in pain	Approve. It will reduce prolonged pointless suffering	Reject	Approve	Moderately strong approval, weaker than when age is unspecified
Passive non-voluntary				
Withdrawal of treatment from a handicapped infant	Approve euthanasia if life deemed not worth living	Reject in most cases. Sometimes acceptance possible if withdrawal is seen as God's will	No prediction, infant is not an autonomous human being	Approval
Withdrawal of treatment from an unconscious dying adult	Approve if life deemed not worth living and no chance of recovery	Reject in most cases. Sometimes acceptance possible if withdrawal is seen as God's will	Approve if death is more dignified than further suffering	Approval
Who should take final decision?	No prediction	No prediction	Proxies best representing patient's own autonomous decision	Next of kin
Active non voluntary				
Life-shortening injection administered to an infant	Approve if awaiting natural death brings on even greater suffering	Reject in all cases	No prediction, infant is not an autonomous human being	Rejection
Life-shortening injection administered to an adult	Approve if awaiting natural death brings on even greater suffering	Reject in all cases	Yes if death is more dignified than further suffering	Rejection

ceteris paribus. But we should see stronger approval for euthanasing patients in great pain compared to situations involving little suffering or good prospects for recovery (Table 1, Panel A). Hence if withdrawal of treatment brings on suffering, 'mercy killing' should be preferred.

Individualism, permeating cultures of most Western societies, is another likely determinant of attitudes concerning euthanasia. Theoretically, it corresponds to arguments akin to the Kantian philosophy, which stress the importance of autonomy and dignity of rational individuals. In situations in which the perceived dignity of the rational human being appears to be compromised by pointless suffering, this approach results in preferring 'dignified death' over 'vegetable-like,

pointless existence' (Table 1, Panel C; *Northern Territory News* 2004). If the willingness to accord the right to die at will to any rational individual underpins attitudes to euthanasia, then the age of patients, their medical condition and particular circumstances should matter little as long as it is clear that their wish to die is sound and rational. Thus, the approval of euthanasia for rational individuals, who desire easeful death, should be high regardless of other circumstances. But there are no predictions from this theory about attitudes towards non-voluntary euthanasia of non-rational individuals. Newborn babies are not considered fully rational and capable of autonomy of decision and, thus, no clear moral guidelines can be derived from the Kantian tradition for action in such cases (Table1, Panel B).

Finally, the commitment to Christianity, which reserves the right to begin and end life to divine agency, also shapes attitudes concerning euthanasia. Christian doctrine, in very broad terms, opposes euthanasia in its every form (except in closely defined cases such as the employment of 'unnatural' means to maintain life). More detailed analyses of the complex links between religiosity and euthanasia are beyond the scope of this paper, but Australia's relative secularity leads us to expect that Christian moral principles underpin views of only a minority (Table1, Panel C).

Data and method

We use data from several large representative IsssA surveys collected in Australia between 1993 and 2002. The IsssA researchers used mail-out questionnaires to collect information about attitudes towards active and passive voluntary euthanasia, with an extended section on non-voluntary euthanasia in 1999 (Kelley and Evans 1999). Utilitarian arguments point to the importance of different medical conditions and the age of a patient as the criteria indicating the quality of life. To establish if and how they influence views on euthanasia, we first examine responses to Likert type questions, showing time trends, and then following with an exploratory factor analysis. This technique determines whether individuals regard active voluntary euthanasia as largely one issue or perceive particular acts of euthanasia as morally different, depending on the age of patients and the nature of their medical condition. The limitations of the data prevent us from analysing the structure of attitudes concerning non-voluntary euthanasia or tracing their dynamics of change. Hence the second part of our analysis focuses on controversies evoked by situations involving either withdrawal of treatment or direct medical intervention to hasten death.

We begin by examining the mosaic of evaluations of various active voluntary euthanasia scenarios, tracking changes over time, where possible.

Results

Active voluntary euthanasia

Earlier studies in Australia and in other Western countries consistently found high public support for active voluntary euthanasia (DeCesare 2000; Jowell *et al.* 1996). The IsssA data make it possible to contrast attitudes concerning four different types of situations in which assisted suicide may be considered. The first occurs when individuals with terminal illness face the prospect of prolonged suffering without any hope for recovery. This is contrasted with situations when hastening death may be contemplated by elderly individuals, who although unaffected by serious illness, feel pessimistic about their future. The third type involves young, permanently disabled adults and the fourth type, young patients with incurable illness.

Terminal illness

In the context of questions regarding opinions about various health issues respondents were asked 'If someone is dying slowly and painfully and wants to end their life, is it right for a doctor to help them commit suicide?' (Table 2, Panel 1).

The balance of opinion in 1993 was in favour of euthanasia, with the average score of 66 points on a scale where 0 denotes 'Absolutely wrong' and 100 'Absolutely right'. The prevailing view was that in most cases incurably ill patients in considerable pain should be able to receive assistance to facilitate suicide, if they wish to hasten their death. But across the spectrum views

Table 2: Attitudes concerning active voluntary euthanasia (%)

Year	Absolutely Wrong (0)	Almost always wrong (17)	Mostly wrong (33)	Sometimes wrong, sometimes Right (50)	Mostly right (67)	Almost always Right (84)	Absolutely Right (100)	Total %	Average Support (out of 100)	*N*
Panel 1. If someone is dying slowly and painfully and wants to end their life, is it right for a doctor to help them commit suicide?										
1993	10	5	3	19	16	15	32	100	66	2115
1994	8	3	3	16	16	17	37	100	66	1454
1996	11	4	3	12	12	14	44	100	71	2584
2001	12	4	3	13	11	15	41	100	71	1492
2002	11	5	3	12	15	20	34	100	66	1341
Total	11	4	3	14	14	16	38	100	70	8986
Panel 2. If someone is young and dying from cancer, (is it) right for a doctor to help them commit suicide?										
1996	13	5	6	17	14	13	32	100	64	2586
Panel 3. If they are very old and do not enjoy their life any more, (is it) right for a doctor to help them commit suicide?										
1993	18	9	9	23	13	10	18	100	51	2120
1994	17	7	9	23	14	11	18	100	53	1455
1996	22	8	10	19	13	10	19	100	50	2583
2001	27	8	10	20	9	9	17	100	45	1491
Total	20	8	10	21	12	11	18	100	50	8993
Panel 4. If someone is young and paralysed, is it right for a doctor to help them commit suicide?										
1996	17	8	11	24	12	8	20	100	52	2585
2001	24	8	10	27	8	7	14	100	44	1492
Total	20	8	11	25	11	8	18	100	49	4077

Note: Scoring of answer categories in parentheses
Source: IsssA 1993–2002

were polarised, ranging from 10% of vehement opposition on one end, to large pockets of ardent support on the other (Panel 1, row 1993) in Table 1. The distribution of opinions remained largely unchanged in later years, although in 1996 and 2001 the average support rose slightly to 71 points, only to fall back to 66 points in 2002.

Young adults and terminal illness

The 1996 survey showed the public also approved of euthanasia of young, incurably ill patients who chose to hasten their death. When asked: 'If someone is young and dying from cancer, (is it) right for a doctor to help them commit suicide?' 32% of respondents answered 'absolutely right', 13% said 'almost always right' and 14% 'mostly right' (Table 2, Panel 2). Only 13% were strongly opposed and this distribution of views resulted in a mean of 64 points of approval. Compared to 71 points of average support for the first scenario (Table 2, Panel 1, year 1996), these 7 points of statistically significant (at $p < 0.01$) difference are a tentative indication of stronger reservations about euthanasia of young, terminally ill adults. But this difference is not large and the balance of opinion is still in favour.

The elderly

Some ethicists draw a distinction between euthanasia to shorten pain when death cannot be averted, and the right to end one's own life for alternative reasons. This is relevant to the debate over the value of individual autonomy and also fears of the 'slippery slope' voiced by euthanasia opponents. Pessimists fear that allowing on-demand euthanasia will open the

door to abuse of vulnerable patients who may feel pressured into hastening their own death by a self-interested family, or economic efficiency concerns, and thus be unable to make truly rational and autonomous decisions (Muller *et al.* 1998). In this view, the legalisation of euthanasia may increase the chance of socially undervalued individuals facing euthanasia against their will.

If respect for individual autonomy is the driving force behind these attitudes, then an absence of terminal illness should make little difference. To explore this issue, respondents were asked: 'If they are very old and do not enjoy their life any more, (is it) right for a doctor to help them commit suicide?'

In 1993, views about euthanasia in the absence of terminal illness were strongly polarised (Table 2, Panel 3); 18% of survey participants disapproved, another 18% were mostly against, and 23% were undecided. On the other side of the spectrum, 23% supported on-demand euthanasia with some reservations, while 18% approved it unconditionally. This polarisation persisted until 2001, when our observations end. Equal numbers of opponents and supporters result in the average opinion of 51 points, denoting the view that euthanasia in such cases is 'sometimes right and sometimes wrong'. This approval is considerably weaker than for euthanasia of the incurably ill. Undoubtedly, the commitment to the value of human life, regardless of a patient's circumstances, is strong. It is consistent with the theological argument that suffering can have a meaning and purpose which ordinary mortals cannot comprehend (McMahan 2002:464). But it can also be linked to the perception that an individual's judgment deeming life not worth living could be erroneous. To evoke the classic Dürkheimian explanation, the desire to end one's own life can be spurred by malleable feelings of disintegration, detachment from the community and a misperception of moral duties.

Nonetheless, it is worth noting that over 40% support the right of the elderly to end their life. Although the average life expectancy has been increasing steadily, the prospect of longer life may not be cherished by all, as many Australians spend their senior years in relative detachment and solitude. In 1997, 32% of individuals aged 65 years and over lived alone. On average, they spent nearly 12.5 hours per day, close to 80% of their waking time, by themselves (Australian Bureau of Statistics 1999).

Young adults and disability

Kantian arguments, emphasising the right of any rational individual to self-determination, disregard differences between young adults and the elderly, and the public also consider them relatively unimportant. In response to: 'If someone is young and paralysed, is it right for a doctor to help them commit suicide?' asked in 1996 and 2001 (Table 2, Panel 4), the average view emerged as an ambivalent 49 points. This was just below the mid-point of 'sometimes wrong, sometimes right' which mirrors responses to the question about an elderly and pessimistic patient. Thus, the age of the person appears to make little difference. A more relevant factor is the nature of the illness or disability. Euthanasia involving young adults unaffected by incurable illness is controversial and perceptions of its moral legitimacy are strongly divided. In 1996: 17% cent objected to helping a young person with a serious disability to hasten their death; another 19% were also against, albeit to a lesser degree; and 24% had ambivalent feelings. On the other extreme, however, 20% were supportive and another 20% expressed unconditional approval. Conceivably these supporters consider individual autonomy most important and approve of assisted suicide in all so far described circumstances. Others find euthanasia on demand difficult to accept.

Changes over time

Prior studies reported that in Australia support for voluntary euthanasia grew between 1960s and mid 1990s (Kuhse 1995). Our analysis shows that subsequently, i.e. between 1993 and 2002, the support for voluntary active euthanasia of the terminally ill plateaued at moderately strong levels (Table 2). In the same time period, euthanasia when death was not imminent evoked strong emotions, dividing opinions equally between unconditional approval and avid opposition. Attitudes remained remarkably stable over time, but in 2001 we observe a small decline in support

Table 3: Pearson correlations and explanatory factor analyses of attitudes to active voluntary euthanasia

	1	2	3	4	Factor loadings	Alpha if item removed
1. Euthanasia when dying painfully	1				0.97	0.89
2. Euthanasia – young, dying of cancer	0.87**	1			0.79	0.87
3. Euthanasia – elderly, does not enjoy life	0.67**	0.70**	1		0.90	0.91
4. Euthanasia – young and paralysed	0.66**	0.77**	0.72**	1	0.74	0.89
					Scale Cronbach's Alpha	.92

** Significant at $p < 0.01$ level
Source: IsssA 1993–2002

for euthanasia on demand. Without more data for later years, however, it is difficult to ascertain that this decline continued.

Structure of attitudes to active voluntary euthanasia

So far we have seen that moral evaluations of euthanasia depend on specific circumstances at least to some extent. Terminal illness is an important criterion affecting acceptance of euthanasia and the age of a patient also seems slightly to influence permissiveness. Given these associations, is it possible to think about euthanasia as a one-dimensional issue about which respondents form simple attitudes, which can be classified in terms of either general support or opposition? Our factor analysis shows that attitudes to active voluntary euthanasia can be efficiently summarised in one dimension, despite slight differentiation in perceptions of specific circumstances.

Individuals inclined to accept euthanasia, approve of it in all four situations described by these survey questions (Table 3). Correlations ranging from 0.67 to 0.87 attest to the high consistency in attitude. Factor loadings are high and, supported by strong reliability analysis, confirm that, although slightly contextualised, active voluntary euthanasia is seen largely as one issue. This demonstrates not only that a significant proportion of Australian society agrees 'that competent incurably ill patients should, in accordance with their values and beliefs, be able to make medical end of life decisions for themselves' (Kuhse 1995:68), but that these respondents also accord similar rights to individuals unaffected by incurable illness. However, this finding does not necessarily imply that views about other types of euthanasia mirror those already discussed. Thus, we next turn to examining attitudes to other types of death-hastening acts.

Passive and active non-voluntary euthanasia

Ethicists debating euthanasia draw a distinction between cases in which the rational and unforced wish to die can be established beyond doubt, and cases in which the patient, a newborn child or a comatose adult, is not self-conscious or able to communicate their will (Munson 2004). Doctors or relatives have to determine a patient's fate and Terry Schiavo's case is a good illustration of the controversy often produced by such decisions.

Withdrawal of treatment in neonatal care

Although some scholars argue there is little difference between an act of active and passive euthanasia (Rachels 1975), empirical research indicates that this distinction is crucial to many ordinary individuals (Hassan 1996; Ho 1998; Miller 1992; Munson 2004). If the concern over the sanctity of human life exerts strong influence on moral positions, norms should be the same for disabled neonates and adults. Yet, if the majority agrees that to be fully human, it is necessary to have 'self-awareness, self-control, a sense of the future, a sense of the past, the

Table 4: Passive and active euthanasia of newborn children and adults

Panel 1.
Sometimes a doctor decides to stop medical treatment of a newborn child with a serious physical or mental defect. As a result the child dies. Do you think...

	%	*N*
The doctor should always continue treatment, regardless of the child's defect	21	325
This should in general be permitted, considering that the child would otherwise be very seriously defective	79	1249
Total	100	1574

Panel 2.
The doctor could decide to end the child's life by taking direct action, for example by giving a fatal injection. Do you think that this:

Should not be allowed	53	812
Should be allowed	47	734
Total	100	1546

Panel 3.
Suppose that a patient is suffering seriously. The situation is medically hopeless. The patient is no longer able to say if he wants his treatment to be continued....

Continue to prolong life	15	228
Terminate treatment	85	1324
Total	100	1552

Panel 4.
Who should take the final decision?

The next of kin	80	1150
Doctors	15	283
Total	100	1433

Panel 5.
Suppose that the doctor can put the person out of his misery by giving him an injection that would end his life. What do you think the doctor should do?

Give the injection	16	248
It depends	54	861
Not give the injection	30	477
Total	100	1586

Source: IsssA 1999

capacity to relate to others, concern for others, communication, and curiosity' (Kuhse and Singer 1985:120); then the norms about the value of lives of babies and adults should be very different. Another possibility is that emotive moral reasoning and the ethics of care evoke greater compassion for helpless children than adults. To gain an insight into these issues the IsssA survey included the following question:

> *Sometimes a doctor decides to stop medical treatment of a newborn child with a serious physical or mental defect. As a result the child dies. Do you think the doctor should always continue treatment, regardless of the child's defect? Or should this in general be permitted, considering that the child would otherwise be very seriously defective?* (Table 4, Panel 1).

The majority, 79%, suggest the doctor should be allowed to stop medical treatment of a newborn if she believes the child's life will be full of suffering and thus not worth living. Religiosity and the ethics of care may underpin views of a minority, but the majority, in line with utilitarian logic, deems it appropriate to weigh the chance

of a happy and fulfilled life against the chance of a poor quality existence. As we shall see, however, this support is reduced when 'letting die' becomes 'killing'.

Life-shortening drugs and end-of-life care of infants

Euthanasia by lethal injection or an alternative form of direct action may be regarded by some as a more humane approach than the withdrawal of treatment and care. Singer (1993:212), for instance, described infants with spina bifida left without treatment, many of whom survived weeks and months of terrible ordeal (see also Munson 2004). In the survey, no position was taken with regard to the relative morality of this practice, and respondents were asked:

> *The doctor could decide to end the child's life by taking direct action, for example by giving a fatal injection. Do you think that this should not be allowed or should be allowed?*

Only 47% supported active non-voluntary euthanasia in this situation (Table 4, Panel 2), in contrast to the widespread acceptance of withdrawal of treatment. Despite an identical outcome for both acts, the distinction made between a 'natural death' and a doctor's intervention to end life becomes critical, and about half the respondents find the latter difficult to accept. This runs counter to the utilitarian logic. Moreover, such polarisation of attitudes indicates a significant potential for conflict in debates over passive non-voluntary euthanasia in infant care.

Non-voluntary euthanasia of adults

Singer (1993:182) argues the moral principles concerning the preferred course of action in cases involving newborn children and adults are profoundly different. The public, however, does not seem to share this view. When asked whether a doctor should decide to terminate treatment for an adult patient in a medically hopeless situation, 85% Australians said 'yes' (Table 4, Panel 3). This consensus closely resembles views about the euthanasia of infants. Moreover, administering death-hastening drugs to unconscious adults meets strong opposition. Only 16% of respondents agreed with the suggestion that a doctor should be able to give the patient an injection to end the patient's life (Table 4, Panel 5); 30% objected while the majority, 54%, was undecided. Although there is little difference in moral evaluations of non-voluntary euthanasia involving adults and infants, the public draw a clear distinction between passive and active non-voluntary euthanasia. The former is acceptable, the latter is not. The crucial moral problem encountered in situations described in this section is the delegation of the authority to determine a patient's fate to an agent other than the patient himself (Cartwright 2000). Hence, we conclude our review by examining the responses to a question regarding this issue, asked in 1999.

If indeed the medicalisation of euthanasia forces doctors to make final decisions (Turner 1997), the public does not approve. Australians are almost unanimous deeming the relatives, rather than the doctor, to be in the best position to decide (Table 4, Panel 4: 80%). This commitment to the notion of according members of the family the final decision, corresponds to established practices in medical institutions (Waddell *et al.* 1996), nevertheless the strength of this commitment deserves attention. It has potentially important implications for future debates over economic efficiency in medically hopeless situations when relatives insist on continuing treatment (Sonnenblick *et al.* 1993). With further development of life-prolonging technologies, more individuals will face this dilemma which will increase the potential for conflict between cost effectiveness and family preferences. When decisions about life and death are considered, as Callahan (1992:53) states: 'the doctor may have no better an answer to those old questions than anyone else; and certainly no special insight from his training ...'

Summary

Between 1993 and 2002 more Australians supported than opposed active voluntary euthanasia. The public approved of helping the terminally ill to hasten their death, largely regardless of the age of the patients. A high degree of consistency characterised these attitudes. Someone who thought a dying person

should be able to obtain help to end their life was also likely to approve of active voluntary euthanasia on demand, although somewhat less readily. The pattern of responses indicates that the commitment to individual autonomy may lead many Australians, close to 50% in these surveys, to approve of active voluntary euthanasia in any circumstance. On the other end of the spectrum, a minority of the practising Christians wholeheartedly rejected any form of hastening death. These perceptions changed very little over that decade, with the exception of a minor decrease in the acceptance of euthanasia involving adults unaffected by terminal illness.

Thus, the arguably increased visibility of euthanasia in the public debate is not an outcome of dramatic changes in the underlying societal norms. It may be that the debate will affect the norms in the future, but so far the public has considered assisted suicide of the incurably ill with substantially less hesitation than the legislators or anti-euthanasia activists. By the end of the 1990s, the public were also supportive of passive non-voluntary euthanasia involving infants and adults. The age of patients did not affect perceptions of this, arguably more controversial, issue. Instead, what shaped attitudes in this instance was the distinction between withdrawal of treatment, which was supported or at least widely considered as something that should be available as an option, and 'mercy killing', which most respondents resent. The importance of this distinction presents a major challenge to future developments of euthanasia-related legislation. It may be that acts indistinguishable from the point of view of the law, may evoke highly conflicting moral sentiments, depending on their perceived status as either acts of omission or commission.

Conclusion

Attitudes concerning euthanasia are diversified and yet form systematic patterns which persist over time. Firstly, Australians have been in agreement that active voluntary euthanasia should be available as an option to terminally ill patients. Moreover, a large proportion of the population accepts all forms of voluntary euthanasia, which points to the strong commitment to individual autonomy as the underpinning motivation. This view, however, is not unanimous as a minority, most likely inspired by Christian moral doctrine, continues to oppose any death-hastening acts.

The difference in support for euthanasia of the incurably ill and those suffering from other types of conditions, may be interpreted as evidence of utilitarian considerations, but such an interpretation is limited. What speaks against it is the contrast between the wide acceptance of withdrawal of treatment, on one hand, and strong negative emotions evoked by any form of direct intervention to shorten life, on the other. As both actions lead to the same outcome, this runs counter to the utilitarian logic. Instead, this points to the lingering commitment to Christian morality, which reserves the right to decide about life and death to divine agency. This distinction is crucial for moral evaluations, but difficult to define in a number of real life situations. Hence the potential for further controversies over particular cases of non-voluntary euthanasia, which some view as murder but others as execution of freedom of choice, remains substantial and may further grow in the future. Despite the degree of polarisation in public opinion concerning moral evaluations of particular situations in which euthanasia may be considered, the amount of support for both active voluntary and passive non-voluntary euthanasia is difficult to ignore. Yet, this support to date remains not reflected in the Australian legislation.

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