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Attitudes of the Secular and Religious Jewish Public in Israel to Euthanasia

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Abstract

Statement of the Problem: Euthanasia is a desire to ease the suffering of the patient suffering from pain due to terminal illness and incurable. On the one hand, opponents of euthanasia argue that the value of the sanctity of life is a supreme value, which is also anchored in the basic law in Israel. Those who hold this position claim that if euthanasia is approved under certain circumstances, this will lead to a devaluation of the sanctity of life, to the extent that the death is allowed even in less obvious cases. On the other hand, advocates of euthanasia argue that the right of a person to die with dignity, the human right to autonomy over his body, and his right not to suffer should be preferred. No studies have examined the relationship between religiosity and the degree of support for euthanasia. Therefore, the purpose of this study is to explore if people with an affinity to religion more opposed to euthanasia

Methodology and Theoretical Orientation: A socio-demographic questionnaire and a questionnaire that examined the degree of religiosity, opinions and attitudes regarding euthanasia included 33 items and was divided to 228 people from the religious and secular sectors

Findings: 74.2% of the study participants belonged to the secular sector, 25.8% to the religious. The greater the degree of religiosity, the smaller the support for euthanasia. In addition, there was a negative correlation between religiosity and all types of euthanasia support ($p<0.001$)

Conclusion and Significance: The issue of euthanasia is a sensitive and controversial issue, and religion has an impact on it. Medical staff should recognize the different points of view increase cultural sensitivity using variety of tools and methods of treatment in order to contribute to the patient's and his family's satisfaction with the end-of-life

Key Words: Euthanasia; Religion; Religiosity; Palliative care

Introduction

Euthanasia is the practice of intentionally ending a life to relieve pain and suffering due to terminal, incurable illness. There are many difficult discussions about the issue of euthanasia from both a legal and moral standpoint, which constitute a key dilemma in medical ethics (Cohen- Almagor, 2002; Soen, 2006) [1,2].

The opponents of euthanasia argue that the sanctity of life is a supreme value also anchored in the Basic Laws of Israel: Human Dignity and Liberty, and must be followed at any cost. According to Jewish law, a person does not own either his/her life or body. It is forbidden to harm one's body, because the body is not our property. The body is a deposit that was given to us by God for safekeeping, and we have no right to cause it any damage. Religion – be it Islam, Christianity or Judaism – is a major component of one's behavior. Health-related decision-making processes in secular cultures are different from decision-making processes in religious cultures (Bar-Ilan, 2003) [3].

The proponents of euthanasia argue that one's right to die with dignity, one's right for autonomy over one's body, and the right not to suffer should not be compromised (Cohen *et al.,* 2018) [4].

To date, a number of studies have been published concerning religion and euthanasia, focusing primarily on Christianity, the attitude of religious physicians toward euthanasia, and active and passive euthanasia and its implications (Danyliv & O'Neill, 2015;

Pool, 2004; Quaghebeur et al., 2009 ;Stolz et al., 2015) [5-8]. In Israel, Soen's research (Soen, 2006) focused on students' attitudes to euthanasia and declared affiliation to religion. Given the scarcity of research on the relationship between these two variables, we have tried to shed some light on the issue [2].

Active euthanasia entails causing death directly, i.e. performing an action to kill the suffering patient or to hasten his/her death, for instance by the use of lethal substances or forces (Baume *et al.*, 2009) [9].

Passive euthanasia entails causing death indirectly, i.e. doing nothing to prevent the patient's death, for instance by withholding treatment, medication, parenteral alimentation, etc. necessary for the continuance of life (Beckwith, 2013) [10]. Many countries have some openness and tolerance for passive euthanasia. Soen's study (Soen, 2006) showed that most Western European countries have passed laws with some variation across countries (worded one way or another) to support termination of life for terminal patients [2].

In Israel, the Knesset, which presented the legislative authority in the state of Israel, passed the 'Rights of the Terminally Ill' act in 2005, allowing clinicians to abstain from extending the life of a terminal patient at his/her request. However, the law specifically states that "nothing in the language of this law allows performing an action, even if it is medical treatment, intended to kill, or the probable result of which is the patient's death, whether or not performed as an act of compassion or grace, and whether or not at the request of the dying patient or any other person" (Ministry of health, 2005) [11]. This law allows performing passive euthanasia on terminal patients, meaning that life extending treatments such as resuscitation, chemotherapy, dialysis, artificial respiration, radiation and others can be discontinued (Soen, 2006) [2]. Active euthanasia is still strictly illegal.

The issue of euthanasia has become a social dilemma. Today, developed countries provide diverse ways for terminal or disabled patients to end their lives, either through active euthanasia or by indirect actions that involve stopping medical treatment or avoiding treatment (Carmel, 2002; Chambaere et al., 2013) [12,13]. However, the variety of available solutions gives rise to ethical and professional as well as economic questions (Danyliv & O'Neill, 2015) [5].

Due to the wide variety of medical treatment and improved technologies and quality of treatment, it is possible to prolong the lives of terminal patients much more than in the past. This also raises moral dilemma, because it entails prolonging their suffering and their difficult physical and mental condition (Carmel, 2002) [12].

The Aim

Few studies have delved into the relationship between one's degree of religiosity or religious faith and his/her support of euthanasia, whether active or passive. Therefore, the aim of this study was to examine the relationship between viewpoints regarding active and passive euthanasia and the degree of religiosity of the adult Jewish population in Israel. In addition, we wanted to examine if there were differences among the population; for example, if a person who defines himself as very religious, who on principle is against euthanasia, would be more inclined to support passive euthanasia as opposed to a secular individual who would be inclined to support active euthanasia. With these insights, we attempted to find tools that might be essential to our work as medical practitioners in cases when we would have to discuss with a religious person alleviating a loved one's suffering.

Our main hypothesis was that a link would be found between a person's degree of religiosity and his/her support of euthanasia, so that the more religious one defines oneself- the more he/she would oppose euthanasia.

Method

Sample

Questionnaires were distributed to 228 individuals, which representative of the Israeli adult Jewish population, belonging to the religious, traditional and secular sectors, and (aged 20 to 80). Two questionnaires were not returned at all and one questionnaire was not properly filled so that the total sample (number of respondents) included 225 subjects.

Research Tool

The questionnaire included 33 questions, divided into three parts:

- Sociodemographic (questions 1-9), which included questions about age, sex, degree of religiosity, level of education, marital status, etc'.
- Attitude to euthanasia (questions 10-22) (Danyliv & O'Neill, 2015) - items on a Likert scale from 1 ('Do not agree at all') to 5 ('Agree completely'); Cronbach's α=0.919. A part that included sayings such as: "It is necessary to support a terminally ill patient in order not to suffer, or, "If I were a professional I would agree to carry out euthanasia provided it is legal", etc [5].
- The Student Religiosity Questionnaire (SRQ) (Katz & Schmida, 2002) (questions 23-33) – items on a Likert scale from 1 ('Never observe') to 5 ('Always observe'); Cronbach's α=0.969 [14]. A part that have tested how much the individual observe the commandments and the demands of Jewish religion (for example: Kiddush on Friday night, Shabbat (the Saturday day) observance and more).

Data Collection

Following approval by the Ethics Committee of Ruppin Academic Center (approbation number 2318-23 L/ND), the questionnaires were distributed via the internet, and the subjects were accessed via the Internet, in groups that participated in various forums dealing with terminally ill patients, chronic pain, treatment and euthanasia in Israel. The questionnaires were filled out anonymously. They were sent directly to the researchers' computer. The All filled-out questionnaires were used. The data were analyzed using SPSS (version 21) statistical software.

Data Analysis

The initial data analysis included descriptive statistics of the sociodemographic data (means, standard deviations, and distribution). The second stage examined the research hypotheses by means of Pearson tests to examine the relationship between the degree of religiosity and support of euthanasia, as well as the relationship between the degree of religiosity and active and passive euthanasia.

Results

The distribution of the research population and sociodemographic data are presented in (Table 1).The sample included 225 participants, and their age range was between 20 and 80. 74.2% described themselves as secular, 14.2% as religious (they are more careful about religious matters), and 11.6% as traditional (which believers in religion but not extremists). The sample included 69.3% women and 30.7% men. 68.1% were married, 19.5% were single, and 9.3% were divorced. 68.6% had an academic education, 19.9% - other tertiary education, and 11.5% - high school education.

Variable	Category	Number of respondents (N)	Percentage (%)
Religion (Jewish)	Secular	167	74.2
	Traditional	26	11.6
	Religious	32	14.2
Age	20-40	113	49.6
	41-60	77	33.8
	61-80	37	16.2
Education	Academic	155	68.6
	Tertiary & high school	71	31.4
Gender	Men	69	30.7
	Women	156	69.3
Country of birth	Israel	189	84.0
	Abroad	36	16.0
Employment status	Employed	162	71.4
	Independent	29	12.8
	Other	31	13.7
Marital status	Married	154	68.1
	Single	44	19.5
	Divorced	21	9.3
Economic status	Below average	85	37.4
	Average	63	27.8
	Above average	79	34.8

Table 1: Distribution of the sample by percentage (N=225)

The degree of religiosity and the degree of support of euthanasia in relation to sociodemographic data are depicted in (Table 2). We found that the younger subjects opposed euthanasia less often than older individuals. Furthermore, the closer one's economic status is to 'average' and one is religious – the more one is opposed to euthanasia; and on the contrary – the closer one's economic status is to 'average' and one is less religious – the more one is supportive of euthanasia ($p<0.001$). No correlation was found between level of education and extent of support for euthanasia, or between degree of religiosity and extent of support for euthanasia ($p>0.05$). The level of education and the degree of religiosity are not related to the degree of support for euthanasia.

As hypothesized, the results indicate that the higher the degree of religiosity, the lower the support for euthanasia is. As the person is more religious he is less support euthanasia or inclined to support it. This tendency is clear and strong ($p<0.001$), as depicted in (Figure 1). We also found that the less religious one is, the more he/she will support passive euthanasia; and the more religious one is, the less he/she will support active euthanasia (Figure 2,3).

Variable	Range/ Category	Religiousness		Support for euthanasia	
		M	(SD)	M	(SD)
Age	20 – 40	2.36	(1.32)	3.75	(0.78)
	41 – 60	2.36	(1.30)	3.77	(1.09)
	61 – 80	1.87	(1.02)	3.90	(0.78)
Gender	Women	2.17	1.20	3.89	0.76
	Men	2.52	1.44	3.55	1.12
Marital status	Married	2.23	1.16	3.89	0.77
	Single	2.00	1.24	3.74	0.91
	Divorced	3.03	1.59	3.28	1.23
	Widower	2.67	1.95	3.28	1.54
Education	High school	2.30	1.21	3.77	0.83
	Academic	2.42	1.37	3.86	0.93
Economic status	Below average	2.31	1.33	3.72	0.92
	Average	2.54	1.41	3.58	1.06
	Above average	2.04	1.05	4.00	0.67

Table 2: Means and standard deviations of degree of religiosity and the extent of support for euthanasia according to the sociodemographic variables

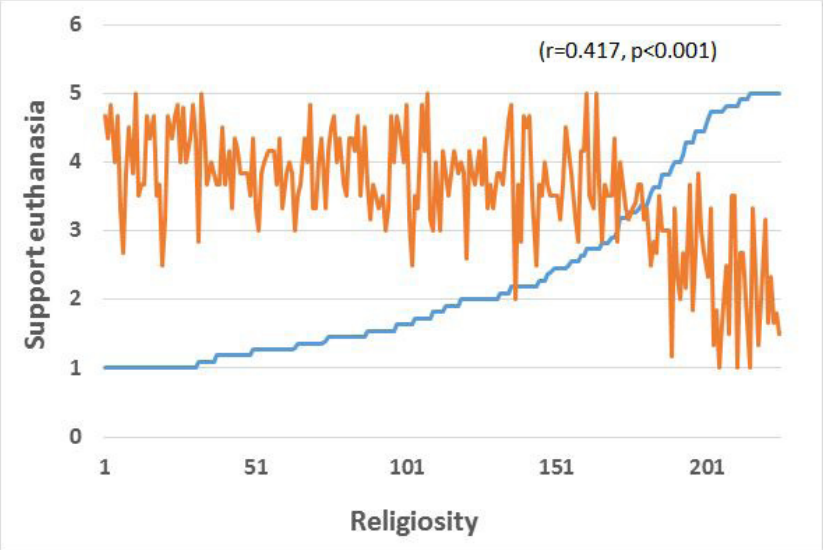

Figure 1: Degree of religiosity and general support for euthanasia

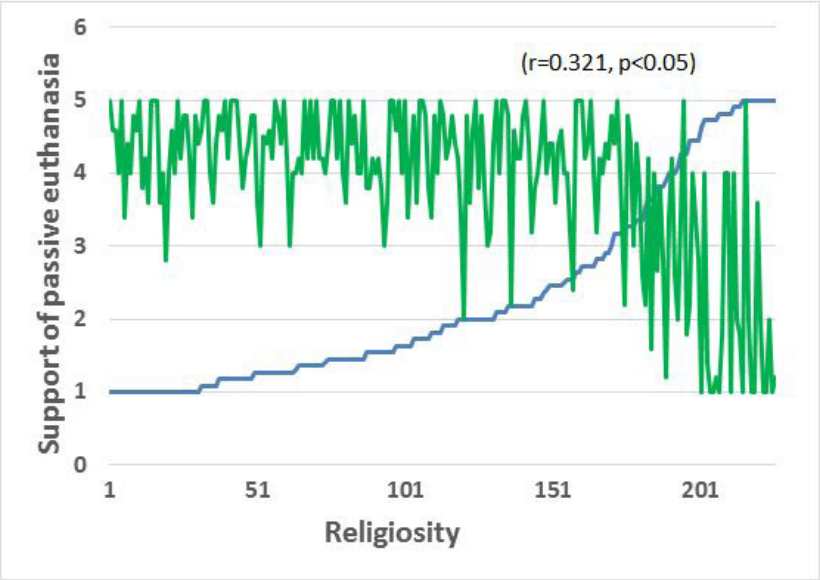

Figure 2: Degree of religiosity and support of passive euthanasia

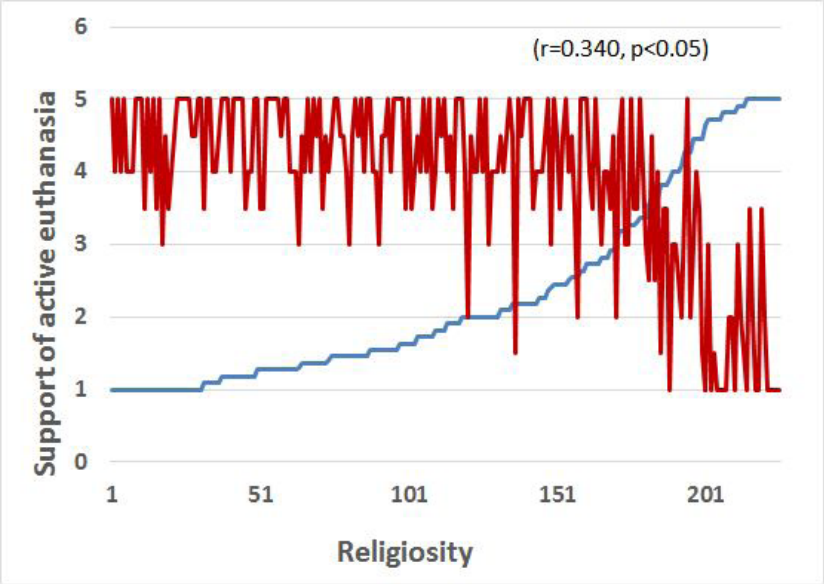

Figure 3: Degree of religiosity and support of active euthanasia

Discussion

This study addressed two central issues: one dealt with the attitudes of the Jewish sector in Israel to (passive and active) euthanasia, and the other related to the relationship between one's degree of professed religiosity and support of euthanasia. The main findings indicate that there is indeed a relationship between one's professed religiosity and support of euthanasia so that the more religious one is – the less he/she supports euthanasia (Aghababaei *et al.,* 2014; Baeke *et al.,* 2011; Bar- Ilan, 2003; Baume *et al.,* 1995; Hains *et al.,* 2013; Head, 1989; Soen, 2006; Stolz *et al.,* 2015) [2,3,8,15-19].

These findings corroborate Cohen et al.'s (Cohen *et al.,* 2006) conclusions; namely that a person's professed religiosity strongly affects his/her attitude to euthanasia [20]. People, who belong to religious groups, spend time at religious places, believe in God and the afterlife, believe in heaven and hell and sin – tend to define euthanasia as immoral. Religion, in fact, affects the meaning that individuals attribute to life and death. This implies that religious people believe in a supreme value to life ('sanctity of life' value), which forbids killing in any situation including medical (Stronegger *et al.,* 2013) [21].

Caddell and Newton (1996), similarly found that people who defined themselves politically as more liberal would be more accepting of suicide and euthanasia than people who defined themselves as conservative [22].

Contrary to our hypothesis, for people with 'average' incomes we found higher correlations between religiosity and support of euthanasia, whereas we conjectured that people with 'high' incomes would exhibit higher correlations between the two variables. This finding corroborates Jorgenson and Nubecker's (1980), argument that the middle classes were more supportive of euthanasia [23,24]. We believe that this specific result in the current study derives from the fact that the gap between 'average' and 'high' income populations in Israel is rather small.

Another surprising finding was that people with tertiary (non-academic) education demonstrated higher correlations between religiosity and support of euthanasia than academics did. We had assumed that the higher one's education, the more aware and liberal one would be.

As posited, younger respondents demonstrated a lower correlation between the variables than the correlation found for the older participants. As expected, we found that people who had experienced an experience close to the issue in question would be more supportive of euthanasia. We also found that men were slightly more inclined to support euthanasia than women were.

In summary, our study found that support of euthanasia, whether active or passive, could be predicted by degree of religiosity, and that it affects the general attitude towards euthanasia. It should be noted that despite signs of progress and although possibilities of euthanasia are increasing and becoming more acceptable – it is still evident that, in traditional societies, the culture, opinions and norms do not change easily.

Limitations

The sampling method was not random – the questionnaires were via internet among an audience that interesting in forums dealing with euthanasia. In addition, the questionnaire items are closed questions with a limited possibility of answers – the respondent's answers could be biased by this. Also, there could be a reliability issue with internet-based questionnaires – supervision is not an option, so that a situation of dishonesty could evolve. Finally, this study is purely in theory- there is no way to know how the respondents would react if they actually encountered a situation in which they would have to take an active stand on this dilemma.

Conclusions

The issue of euthanasia is a delicate and controversial issue, which we recommend treating with seriousness, consideration and sensitivity to peoples diverse views – even if they contradict medical recommendations.

Having found differences between groups of the population, we believe that it is very important to impart these insights to medical personnel -first, to become acquainted with the various viewpoints, and secondly, to increase cultural sensitivity to the issue and to create diverse tools and treatment methods that can contribute to the satisfaction of the patients and the patient's family with medical care at the end-of-life phase.

Following the literature review and the outcome of this study, we would recommend further research to examine whether matching the physician's cultural/religious sector to that of the patient could increase satisfaction with the treatment offered to the terminally ill patient. We believe that this could greatly benefit following points:

- Reducing conflicts with the medical staff and increasing the family's cooperation;
- Increasing response to medical treatment;
- Openness and attentiveness;
- Reducing anxiety levels of the patient and the patient's family at the end-of-life phase.

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