

DEATH AND DYING: AN INVESTIGATION OF FACTORS THAT INFLUENCE SUPPORT FOR EUTHANASIA AMONG THAI PEOPLE*

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Abstract: The present study investigated how Thai people regard euthanasia and their level of support for different types of euthanasia (e.g., active versus passive, voluntary versus non-voluntary). A total of 1,928 participants voluntarily filled in the study's questionnaire. Exploratory (EFA) and confirmatory (CFA) factor analysis of the Euthanasia Scale (Ho, 1998) identified and confirmed a two-factor structure that emphasized the voluntary-non-voluntary dimensions of euthanasia. The findings also parallel those obtained from Ho's (1998) Australian study and suggest that Thais and Australians hold similar beliefs about the concept of autonomy, a concept that emphasizes the individual's right to make decisions for themselves on the style and quality of their lives.

Keywords: Euthanasia, Active Euthanasia, Passive Euthanasia, Non-Voluntary Euthanasia, Voluntary Euthanasia.

Introduction

The term *euthanasia* was coined by the historian W. E. H. Lecky in 1869. Derived from the Greek word for "happy death" or "good death," the term *euthanasia* traditionally conveyed the idea of keeping terminally ill patients free from pain in their last days. In recent years however, this has come to mean much more (Anderson, 1987). The Webster's Dictionary has provided the following two common definitions of euthanasia which showed a shift in emphasis from a pain-free death to one that focused on the way death is brought about: (1) "an easy death or means of inducing one" and (2) "the act or practice of painlessly putting to death persons suffering from incurable conditions of diseases" (Webster, 1971). While public opinion polls in the West have consistently shown moderate to high support for euthanasia, the discussion and debate over the issue of euthanasia have often been clouded by the nature of the topic itself. That is, although much of the debate had focused on the right of a person to 'die with dignity', it is often not clear what kinds of euthanasia were being discussed. Specifically, the discussion and

debate have tended to treat euthanasia as a singular concept about the right to death, when in fact the decision to end life relates to different decision-making processes including voluntary euthanasia, nonvoluntary, involuntary euthanasia, passive euthanasia, and active euthanasia.

Attitudes toward euthanasia and its support have remained problematic because the term itself can be ambiguous depending on the country and culture the practice is considered. For example, in Japan, the Japanese term 'anrakushi' (euthanasia) literally means peaceful and comfortable death. The carefully crafted distinctions, based on western bioethics, between active, passive, voluntary and non-voluntary euthanasia are literally meaningless when considered against a society where the right to a peaceful and comfortable death is an accepted option rather than as an issue for debate. The distinction made in western-based bioethics between physician-assisted suicide (active-voluntary) and euthanasia seems to have little relevance in Japan. In Thailand, as in many Asian countries, Buddhism is identified as the authority *par excellence* on matters relating to death, and is closely linked to the rites and ceremonies associated with the transition from this life to the next one. Buddhist teaching emphasizes the importance of meeting death mindfully since the last moment of one's life can be particularly influential in determining the quality of the next rebirth (Bhikkhu, 2000). Because death is not regarded as a permanent loss but is part of the cycle of existence and rebirths, Thai people seem to accept death more readily than westerners (Ratanakul, 1995).

In Thailand, the law does not provide any specific offense in the case of euthanasia and in fact, the Thai Criminal Code concerning medical activities ignores completely the word "euthanasia". The lack of specific laws on euthanasia means that punishment will be meted out under preexisting offenses (Sokontha, 1986). For example, active euthanasia can qualify as murder under Section 288 of the Criminal Code which provides that "*whoever commits murder on the other person shall be punished with death, imprisonment for life or imprisonment of fifteen to twenty years*". Similarly, passive euthanasia qualifies as an offence of abandonment. Section 307 of the Criminal Code states that "*whoever, having duty by law or under a contract to take care of a person who is in a helpless condition through...sickness, infirmity in body or mind, abandons such person in a manner likely to endanger his life, shall be punished with*

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imprisonment not exceeding three years or fine not exceeding six thousand baht, or both".

A report of the Committee on Women, Youth and Elderly Affairs of the Senate was submitted to the Thai Parliament in July 1997. This report contained a proposal that Thailand should have a law on euthanasia that gives a person the right to refuse medical treatment. The proposed law provides a person the right to express his will in writing while he is fully conscious or by the decision of the attending doctor and his family. In an update provided by Parliament on 26 May 2011, it was noted that the Thai Parliament finally enacted into law The National Health Act of 2010 (issued under Section 12 of the National Health Act of 2007) which has an article that states that all Thai citizens retain the right to express the desire to not have a medical facility delay their passing when imminent or when doing so would also prolong suffering. By enacting this law, Thailand has now joined the ranks of those countries that have legalized (passive) euthanasia.

In order to clarify and to understand how Thai people regard euthanasia, the present study investigated how Thai people perceived the issue of euthanasia in terms of its sub-components of active, passive, voluntary, and nonvoluntary euthanasia, as well as their level of support for these different types of euthanasia.

Method

Participants

The sample consisted of 1,897 participants (719 males, 1,178 females) recruited via convenience sampling technique from different parts of Bangkok. All participants were Thai nationals, over 18 years of age, residing in Bangkok at the time of the study and who volunteered to fill in the study's questionnaire.

Materials

The questionnaire employed consisted of three sections. Section 1 contained items written to elicit the participants' demographic information of gender, age, level of education, marital status, employment rank, and monthly income.

Section 2 consisted of the 12-item Euthanasia Scale (ES) developed by Ho (1998). The 12 items tap the level of support for four types of euthanasia (active-voluntary, active-nonvoluntary, passive-voluntary, passive-nonvoluntary) yielded by the 2 x 2 factorial combination of the 'active versus passive' and 'voluntary versus nonvoluntary' subcategories. Each item was to be rated on a 5-point scale that ranged from 1=strongly disagree, 2=disagree, 3=undecided, 4=agree, and 5=strongly agree, with high scores indicating stronger support for that type of euthanasia.

Section 3 consisted of 18 items written to tap the level of support for euthanasia under three conditions of suffering – physical pain (6 items), incapacitated nature of the body (6 items), and impact/burden on the family (6 items). It should be noted that these variables were not investigated in the present study.

Procedure

After receiving the approval from the Committee for Graduate School of Psychology, Assumption University, the potential participants were approached and were informed of the general nature of the study, i.e., to investigate people's attitude toward euthanasia. Participants were then invited to fill in the study's questionnaire. They were informed that (1) they could withdraw from filling in the questionnaire at any time, (2) no names were recorded to guarantee the participant's anonymity, and (3) the data collected were to be used only for the purpose of this study and only by the researcher and her advisor. The final sample of 1,897 participants was recruited via convenience sampling from different parts of the city, shopping malls, and business offices.

Results

Stage 1: Exploratory factor analysis

From the total sample of 1,897 participants, a random sample of 964 participants (approximately 50%) (Male: $n=376$, 39%; female: $n=588$, 61%) was selected for the exploratory factor analysis (EFA) stage of the study. Inspection of the main EFA results revealed that two factors had eigen-values greater than 1.00. In conjunction with results obtained from the scree-plot, these findings suggested a two factor solution. These two factors accounted for 43.44 and 10.09% of the total variance respectively, for a combined total of 53.53%. From the obtained pattern matrix, a total of 11 items were retained, using the criteria of selecting items with factor structure coefficients greater than or equal to 0.40 and no significant cross-correlations. The use of the 0.40 value as a criterion for selecting items is based on the logic that squaring the correlation coefficient (0.40^2) yields approximately 16% of the variance explained. Of the 11 items, 5 correlated with Factor 1 and 6 correlated with Factor 2. Examination of the items that correlated with these two factors indicated that Factor 1 consisted of items that reflected attitudes toward voluntary euthanasia (e.g., *Terminally ill patients have the right to decide that life supporting drugs or mechanism be withheld or withdrawn, to hasten their death; Terminally ill patients have the right to decide about their own lives and deaths*). Factor 2 consisted of items that reflected the participants' attitudes toward nonvoluntary euthanasia

(e.g., *When a patient is suffering a debilitating terminal disease such as Alzheimer’s, it is alright for the doctor to administer medication that will painlessly end the patient’s life, if members of the patient’s family request it, Doctors have the right to administer medication that will painlessly end the life of a patient who has been diagnosed to be in a permanent “vegetative” state, if members of the patient’s family request it).*

Stage 2: Confirmatory factor analysis

Confirmatory factor analysis (CFA) was carried out to evaluate the adequacy of the factor structure identified via exploratory factor analysis. CFA, unlike exploratory factor analysis, allows the researcher to explicitly posit an *a priori* model (e.g., on the basis of the factors identified through exploratory factor analysis) and to assess the fit of this model to the observed data. Based on the factor structure identified through exploratory factor analysis, a two-factor model representing voluntary and nonvoluntary euthanasia was posited. For this measurement model, the two latent constructs of ‘voluntary euthanasia’ and ‘nonvoluntary euthanasia’ were represented by 5 and 6 indicator items respectively (generated from EFA in Stage 1).

Figure 1 presents the two-factor measurement model representing the two latent constructs of ‘voluntary euthanasia’ and ‘nonvoluntary euthanasia’. For this model, all factor loadings were freed, measurement indicators were allowed to correlate with only one factor, and the two factors were allowed to correlate (equivalent to oblique rotation).

Participants

From the total sample of 1,897 participants, 964 participants were selected for the previous exploratory factor analysis part of the study (Stage 1). The remaining 933 participants (male: $n=339$, 36.3%; female: $n=594$, 63.7%) were selected for the present confirmatory factor analysis of the study (Step 3). Their ages ranged from 18 to 66 years and over, with a mean age within the range of 26 to 35 years.

Materials

Participants responded to the same questionnaire as those who participated in Step 1 (exploratory factor analysis) of the study. To reiterate briefly, the questionnaire consists of three sections. Section 1 contains items written to elicit the participants’ demographic information relating to their gender, age, level of education, marital status, employment rank, and monthly income. Section 2 consists of the 12-item Euthanasia Scale (ES) developed by Ho (1998). Section 3 consists of 18 items written to tap level of support for euthanasia under three conditions of suffering – physical pain (6 items), incapacitated nature of the body (6 items), and impact/burden on the family (6 items).

Results

The purpose of this phase of the study was to evaluate the posited *a priori* model of voluntary and nonvoluntary euthanasia (Figure 1). A χ^2 goodness-of-fit test (via structural equation modeling) was employed to test the null hypothesis that the sample covariance matrix was obtained from a population that has the proposed model structure. Table 1 presents the goodness-of-fit indices for this model.

(See on the next page)

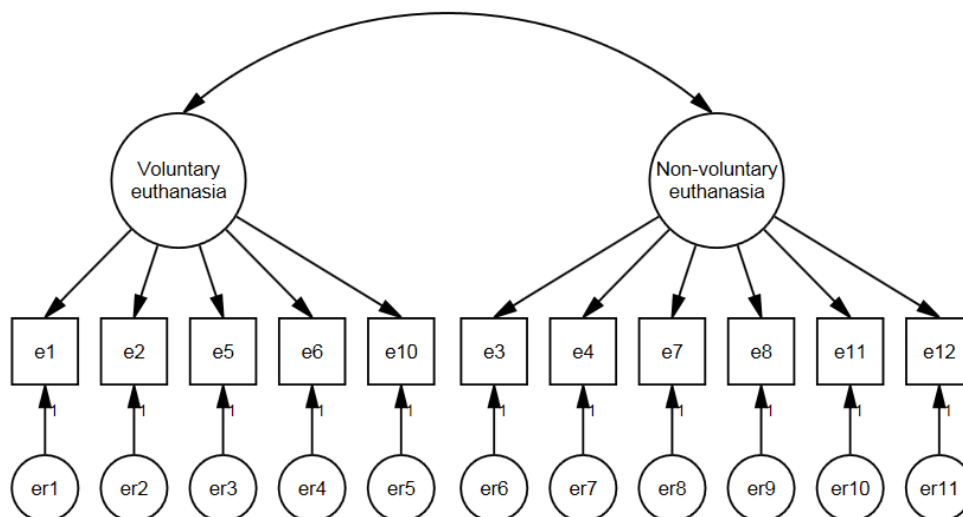


Figure 1: Two-factor measurement model representing the latent constructs of voluntary and nonvoluntary euthanasia

Table 1: χ^2 goodness-of-fit Value, Normed Fit Index (NFI), Incremental Fit Index (IFI), Tucker-Lewis Index (TLI), Comparative Fit Index (CFI), and Root Mean Square Error of Approximation (RMSEA)

Model	$\chi^2 (N=933)$	df	p	NFI	IFI	TLI	CFI	RMSEA
Null Model	3866.27	66	<.001	0.00	0.00	0.00	0.00	0.25
Two-factor Model (voluntary and non-voluntary euthanasia)	275.35	43	<.001	0.93	0.94	0.91	0.94	0.07

Although the overall chi-square value was significant, $\chi^2(df=43, N=933) = 275.35, p<.001$, the incremental fit indices (Normed Fit Index – NFI, Incremental Fit Index – IFI, Tucker-Lewis Index –

issues, inspection of parameter estimates, goodness-of-fit, and interpretability. Table 2 presents the standardized regression weights, residuals, and explained variances for the two-factor model.

Table 2: Standardized Regression Weights, Explained Variance, and Residual Variances for the Voluntary and Non-Voluntary Indicator Variables

Parameter	Standardised Regression Weights	Explained Variances	Residual Variances
Voluntary euthanasia \rightarrow e10	0.67	0.45	0.55
Voluntary euthanasia \rightarrow e6	0.76	0.58	0.42
Voluntary euthanasia \rightarrow e5	0.78	0.61	0.39
Voluntary euthanasia \rightarrow e2	0.77	0.59	0.41
Voluntary euthanasia \rightarrow e1	0.71	0.51	0.49
Non-voluntary euthanasia \rightarrow e12	0.52	0.27	0.73
Non-voluntary euthanasia \rightarrow e11	0.62	0.39	0.61
Non-voluntary euthanasia \rightarrow e8	0.62	0.39	0.61
Non-voluntary euthanasia \rightarrow e7	0.73	0.53	0.47
Non-voluntary euthanasia \rightarrow e4	0.67	0.45	0.55
Non-voluntary euthanasia \rightarrow e3	0.55	0.30	0.70

TLI, Comparative Fit Index – CFI) are all above 0.90 (range: 0.91 – 0.94). These fit indices indicated that the model provided a good fit relative to a null or independence model (i.e., the posited model represented over 90% improvement in fit over the null or independence model), and support the hypothesized structure of the posited voluntary – nonvoluntary two-factor model. The RMSEA value of 0.07 is also within the range suggested by Browne and Cudeck (1993) and indicates that the model fits the population covariance matrix reasonably well.

While the above fit indices can be used to evaluate the adequacy of fit in CFA, it must be noted that this is only one aspect of model evaluation. As pointed out by Marsh and his colleagues (e.g. Marsh, 1996; Marsh & Balla, 1994; Marsh, Hau, & Wen, 2004), model evaluation should be based on a subjective combination of substantive or theoretical

The standardized regression coefficients (factor loadings) for the measurement indicators were all positive and significant by the critical ratio test, $p<.001$. Standardized loadings ranged from 0.52 to 0.78 ($M = 0.67$). These values indicated that the measurement indicator variables hypothesized to represent their respective latent voluntary and nonvoluntary euthanasia constructs did so in a reliable manner. The percentage of residual (unexplained) variances for the 11 indicator variables ranged from 39% (i.e. 61% of the variance explained) (e5) to 73% (i.e. 27% of the variance explained) (e12).

Discussion

The substantive purpose of Study 1 was to investigate how Thai people regard euthanasia via identification of the factor structure of the Euthanasia Scale (Ho, 1997). Initial exploratory factor analysis of responses

derived from the ES identified a two-factor structure representing attitudes toward voluntary and nonvoluntary euthanasia. Confirmatory factor analysis confirmed and further clarified the adequacy of this factor structure in representing attitudes toward voluntary and nonvoluntary euthanasia. Together, these findings point to the importance of the sub-categorical distinctions of voluntary versus nonvoluntary euthanasia in influencing attitudes toward life and death issues. In essence, for the study's participants, the decision to support or not to support euthanasia appears to key primarily on the basis of the presence or absence of the wish of the patient to die. These findings corroborate Ho's (1998) argument that the decision regarding the termination of life is determined primarily by the perceived morality of a decision made on the basis of whether or not consent has been given by the patient. Simply, when consent had been provided by a person, or when the person had specifically asked to die, or had left specific instructions about when euthanasia was wished, then people would feel less morally insecure about terminating the life of that person.

The study's findings also parallel those obtained from Ho's (1998) Australian study. Specifically, both studies, which employed the same exploratory (EFA) and confirmatory (CFA) data reduction techniques on the Euthanasia Scale, identified the same factor structure that emphasized only the voluntary-nonvoluntary dimensions of euthanasia. Thus, it appears that regardless of their cultural (Western vs Asian) and religious (Christians vs Buddhist) differences, Australians and Thais are very similar in how they regard euthanasia. That is, their decision to support or not to support euthanasia is motivated primarily by the presence or absence of the wish of the patient die. This similarity appears to reflect the belief that both Thais and Australians hold about the concept of autonomy, a concept that emphasizes the individual's right to make decisions for themselves on the style and quality of their lives. According to Wanser et al. (1989), to deny that people are capable of making such judgments about their own lives is to deny the humanity and common sense that we all share.

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