Euthanasia: sociological perspectives

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The potential of medicine to intervene to prolong or shorten the life of those considered to be dying or of those whose life is rated as of little or even negative value has only recently surfaced. It is an issue likely to affect society and the normative social relationships which that society believes it is its duty to promote. It is probable that, covertly, members of the medical profession have long played a role in speeding up the process of dying, with or without the consent of affected individuals. The openness, however, with which the moral issues involved in hastening or prolonging life by medical means are now discussed is a late 20th century phenomenon. Sociologists are beginning to study the circumstances surrounding the issues and the wider societal implications of possible changes in the law, professional practices and normative values. Their work may well begin to influence public policy as well as private practice.

Sociological approaches to ethical dilemmas

Have the disciplines of sociology or social anthropology a significant contribution to make to the understanding of euthanasia or to the current world-wide debate about the legitimacy and morality of its practice? This is the question which we consider in this chapter.

Sociologists are interested in the factors which lie behind the formation and maintenance of the normative and deviant judgements which are made about the morality of any form of human behaviour. They are open to the suggestion that some forms of behaviour attract such almost universal opprobrium that their repudiation constitutes an in-built requirement for the stability and survival of human groups. In the main, however, they seek explanations for observed variations in normative practices, beliefs and values.

Many, perhaps most, sociologists also hold strong beliefs about the morality of those end-of-life decisions which include euthanasia, however that term is defined. As scholars, however, they seek to separate their disciplinary approach to the subject from their personal predilections. In so far as they become protagonists in the contemporary debate on salient moral issues, they would claim to do so as citizens rather than as social scientists.
A specifically sociological approach to euthanasia seeks to locate it within a general social, cultural, economic and political context. It would be seen as embedded in a particular set of functions governed by the accepted social *mores* for dealing with dying and death in any given society. The sociological assumption would be that the ways of relating to dying persons, which are seen as right and appropriate, reflect the society’s dominant values and beliefs concerning life and death. The procedures associated with dying must also be compatible with the general moral standards accepted as normative. The rituals employed; the extent to which efforts may be made to hasten or postpone the moment of death, or deal with the physical pain and emotional distress experienced by survivors as well as the dying; the authority to act which is vested in those who claim expertise in curing or caring or in those who claim kinship with the dying person—all such matters are seen by sociologists as socially constructed.

Not surprisingly, those who are often called the founding fathers of sociology as an academic discipline threw little direct light on the specific practices surrounding death and dying in general, let alone euthanasia. However, some of the pioneers of social anthropology, who sought to understand the constants and the discontinuities in human social behaviour and beliefs, were fascinated by the ways in which death was perceived and treated in exotic societies, very different from their own industrialised post-enlightenment one.1 These early social scientists, however, made some important observations about factors contributing to social solidarity and continuity and about the factors leading to social change. Durkheim, for example, made the important observation that the frequency of suicide (a form of end-of-life decision) in modern industrial societies was related to social structures and to the extent to which societies valued individual liberty as against social solidarity2.

**Why is euthanasia now on the agenda?**

**The ageing population and advances in medical technology**

The absence to date of any substantial body of sociological work on euthanasia—defined here as measures designed to hasten or procure death—is not surprising. To begin with, the debate in western society about the morality and regulation of end-of-life decisions is itself relatively recent. It could result from the potentially destabilising effects on the collectivity of a new phenomenon—the survival of increasing numbers of very old or very handicapped individuals in its midst.
The reasons for the substantial shift in the age structure of populations are multiple and do not need to be detailed here. Briefly, they include economic growth and changes in the physical environment, life style and reproductive behaviour which began to accelerate, at least in the western world, in the 19th century. In the second half of the 20th century, however, technological advances in the biomedical sciences and their application to human populations have also played a major part in the prolongation of life in general and in particular of lives which, in former times, as a result of injury or disease, would have ended much earlier than in old age.

The demonstrations of medical power over life and death have met with an ambivalent response, not least among members of the fraternity itself. We are now able to keep alive or resuscitate human beings whose continuing existence is valued neither by themselves nor by others. Should medicine always exercise this power? Or should it use its knowledge and authority to assist those who no longer wish to live (and those whose continued existence appears to absorb much of the community’s resources which could be devoted to other valued objectives) to achieve a dignified death? In the changing social climate will older people feel increasing pressures on them to permit the withdrawal of life-sustaining measures? If doctors are believed to be willing to exercise their skills to procure death, will older people lose their faith in the intrinsic benevolence of the profession?

Most sociologists would agree with the proposition that the salience of the issues surrounding decisions to take human life has increased at least partly as a result of the horrific events of the 1930s and 1940s culminating in the holocaust. During that time, a minimum of 6 million Jews, and countless numbers of gypsies, mentally and physically disabled people and political dissidents were brutally and deliberately eliminated as a matter of state policy.

To suggest a resemblance between the specious justification of their deeds by the Nazis and the stance of those who argue that the lives of some individuals have become valueless to them and that in such circumstances they should be assisted, if they so wish, to end their existence, is grotesque. Comparing apparently diametrically opposed views on human dignity and autonomy could be regarded as no more than a debating ploy aimed at undermining the moral standing of the proponents of some form of legalised euthanasia by those who are not prepared to envisage the shortening of human life in any circumstances. Nevertheless, the spectre of a ‘slippery slope’ and of a potential travesty
of humanitarian objectives if the state were to permit doctors to end lives in specific circumstances exercises a not inconsiderable influence on public opinion in general and legislators in particular. The situation in The Netherlands, where doctors have such power, is being closely scrutinised in other western countries.

AIDS

A third phenomenon which has also helped to destabilise cultural presumptions about how death and dying should be treated has been the advent of AIDS-related illnesses. It has brought back the haunting spectre of inevitable death in early adulthood to those already identified as affected by HIV. Among them, at least in western countries, are young, middle class, intellectual and artistic individuals who want to take a full part in determining how their dying and death are managed.

The changing cultural milieu

The impact of revolutionary technological change on the way in which those of us alive today make sense of the world and our own individual identities within it is incalculable, and essentially paradoxical. There is the demonstrable power of modern technology to provide a very high proportion of the world's current population with a wealth of experiences which would have been unachievable fantasies for any human being who died before the end of the 19th century. The extension of our horizons in this way must be attributed to the development of scientific thought and its application to the tasks of satisfying insatiable human demands for 'the good life', however differently this may be conceived by individuals.

Nevertheless, the exponential changes which have already taken place in the last few decades have failed to satisfy the age-long human search for meaning. Indeed, the irrelevance of scientific paradigms in pursuing the goal of ascribing meaning to human existence has triggered a variety of popular responses. One of these is a backlash against what is now seen as the tyranny of positivistic scientific thought and those identified as its orthodox proponents, including the medical profession. In particular, there has been a growing popular desire in the last one or two decades to take management of dying out of the hands of professionals and, as far as possible, to enable dying people themselves to control end-of-life decision-making. The strength of these desires is manifested in the increasing use of advance directives; in the growing trend towards
palliative care and for deaths to take place in hospices or with hospice support at home\textsuperscript{14}.

**Recent sociological approaches to dying**

Sociologists have in recent years begun to build a body of empirical evidence about how death and dying are handled in the contemporary world\textsuperscript{15}. The observations they have made in hospitals and hospices have been used to make certain generalisations about what constitutes ‘a good death’ and what an unsatisfactory one. These studies have been supplemented by the systematic collection of accounts taken mostly after death from those believed to have been closest to or responsible for the dying person\textsuperscript{16}. Most of these studies have not tackled directly the issue of euthanasia; but one recent study in the UK invited relatives to say whether they and the dead person would have wished for death to have taken place earlier than it in fact did\textsuperscript{17}.

Awareness of the pain and suffering (psychological as well as physical) which, it is usually assumed, the process of dying involves has been a major deterrent to sociologists collecting data about it. To obtain information and so understand the experience of dying, sociologists would ideally like to observe it as it is being experienced first hand. More and more human behaviours or attributes are now seen as legitimate ones to question individuals about, if not to observe. At one time, it was not permissible for social survey researchers to ask individuals about then-age or income. Now it is not uncommon for people to agree to provide researchers with information about their sexual behaviour, including the frequency of intercourse or the number of partners and/or orgasms they have had in a given period of time.

There is reluctance, however, to invade the physical and temporal space around the dying person which is seen as legitimately occupied exclusively by kin, close friends and professional carers. There may also be a fear of confrontation with a situation which challenges the capacity for emotional self-control and may act as an unwelcome reminder of personal mortality. The reasons for such reluctance are not difficult to understand. Given increasing concern to protect patients from what might be interpreted as intrusion, it is unlikely to change much in future\textsuperscript{18}.

The result is that systematic evidence about the emotional responses experienced by dying people has been largely secondhand\textsuperscript{19}. One notable exception is a recent study carried out, like most other studies of dying, with people dying of cancer\textsuperscript{20}. Most research, however, has had to rely on the accounts of kin or professional carers after the death. The studies are
of variable quality and reflect, among other things, the degree of warmth and understanding which existed between the informant and the dead person. Other kinds of account—for example those from individuals who claim to have experienced a resurrection—are, if not suspect, so unusual as not to be entitled to any form of generalisation. So too are accounts given by mediums who claim to put living relatives in touch with their dear departed.

It is likely that obtaining firsthand coherent accounts of those who are dying and might wish to exercise the choice of dying earlier by being able to call on their professional carers or relatives to help them will continue to be difficult. Indeed, it is possible that, given age trends in mortality, more of those dying in the future than at present will be suffering from some degree of dementia at the time and hence not regarded as competent to express an opinion. The still uncertain prospects for AIDS mortality may modify this prediction.

Agencies in the determination of euthanasia practices and policies

One of the main interests of sociologists is in what they call ‘agency’, a term which has a broader meaning for them than it has for lawyers. By it they mean the social institution which has by legal authority or common consent the recognised right to set and control the normative practice in any given field of human activity. In the case of end-of-life decisions, the agency is shared and the desirability of the power distribution between actual and potential agents is disputed. Indeed, the current debate on euthanasia is at least partly about agency, about who does and who should control the decisions to hasten or procure death.

The medical profession

In western societies, the major agent in end-of-life decisions is the medical profession. Public perceptions of the technical competence of its members and the widespread desire of those in vulnerable situations to endow them with superior dispassionate moral values give them a high degree of popular licence to take problematic, uncomfortable decisions. Nevertheless, individual members of the profession, although frequently faced with the responsibility of taking measures which may shorten or prolong life, have had little if any formal instruction in how to consider the ethical or legal questions intrinsically involved in the decision making. Consequently, their actions reflect individual beliefs, those of the caring
teams with whom they work, and their perceptions of the law and of the
wishes of the dying person's next-of-kin and of the dying person her or
himself, rather than any generally accepted professional stance. This pot
pourri may well lead to different outcomes in clinically similar situations.

Representative bodies of doctors have aired the issues and taken
positions on some of the ethical and procedural ones. But the enormity
of the task, when stated bluntly, of 'playing God', has made many
members of the profession and its leaders call for firmer guidance if not
direction from legislators or from judges on how and when individual
doctors should exercise their powers.

Priests and religious leaders

In western, secular societies, priests of the major Christian religious
traditions are fighting a losing battle to retain the popular authority on
such questions which they once indubitably held. They are less powerful
than they once were to influence the outcome of the debate about the
legitimacy and regulation of different ways of handling the desires and
fears of dying people. Nevertheless, to a greater or lesser extent, they are
protagonists of particular viewpoints which they seek to reconcile with
the basic tenets of their faith. The Roman Catholic church in particular
still exercises, directly or indirectly, considerable influence on decisions
whether to sustain the life of new-borns with only the prospect of a short,
restricted existence requiring dedicated sacrifice from kin and carers and
substantial opportunity costs to the community.

The media

The media, too, must be counted another independent agent or force of
considerable contemporary weight. Responding to multiple influences
from their customers—namely their readers, viewers, listeners and
advertisers—as well as from their governing bodies, they engage
increasingly if not always over-scrupulously in activities designed to
draw more and more people into the arena where moral and ultimately
political issues are debated.

The power of the media to persuade health authorities and government
effectively to ignore priorities (often set up to ensure that 'cinderella'
services are adequately funded) in favour of expensive procedures
designed to save the life of a single individual (with a probably negligible
disability-free life-years' expectation) is exercised relatively frequently.
Unfortunately, the media seldom recognise explicitly any obligation to
present their audiences with a full enough picture of the issues to ensure that public opinion is truly informed.

**Pressure groups**

Other groups representing particular widely held opinions, such as the sanctity of life in all circumstances\(^2^9\), or, conversely, the 'natural' right of individuals to ask for assistance in ending a painful existence\(^3^0\), have also become significant actors seeking to exercise an influence on public opinion and, possibly, on the legislative framework governing end-of-life decisions.

**The wider social implications of societal arrangements for end-of-life decision-making**

In this paper, we have pointed to the general factors, demographic, technological, economic and cultural, which, as sociologists, we believe are responsible for the present public manifestation of intensifying interest in euthanasia. We have suggested that the social agencies involved are either those assigned a major role in the management of dying, or those regarded as guardians or interpreters of the moral standards of the society. The media facilitate the exchange of opinions and in doing so act as agents of either change or reinforcement of traditional values.

As sociologists, however, we would also stress the interconnectedness of societal beliefs and practices concerning death and dying and those to do more generally with issues of the autonomy and conversely of the dependency of individuals.

**Dependency and autonomy**

The issue of dependency is intimately bound up with that of euthanasia. In one of the few studies to address such issues through the medium of next-of-kin informants, the desire to speed up the end of life appeared to be related to feelings about the loss of independence in everyday living\(^1^7\). Such feelings were said to be felt by both the dying person and her or his relative or friend.

Indeed, there is a cultural abhorrence of relying on others to provide care, particularly in the most personal and intimate tasks of daily living. In modern societies which place a high value on reciprocity in
relationships as well as on autonomy, adult dependency is regarded as undignified, leading to a loss of self-esteem by those requiring care, no matter how willingly or lovingly administered. Moreover, the dependency of one person on another, if accepted, inevitably involves a reduction of choice and hence of autonomy on the part of that other. Although studies have shown that the dependency of an elderly, frail person is in most instances accepted—and in many instances is seen to bring its own rewards—there is none the less a growing consciousness that the decision to accept that dependency could be construed as yielding to a form of moral blackmail. The success of the blackmail is the product of a strong fear of adverse social judgements, whether or not such a fear is justified.

The advance directive or living will is an attempt on the part of individuals to insure their autonomy in circumstances in which their dependency on others may reach a level which they consider unacceptable. The impact of a great extension in the practice of giving doctors advance directives requesting them to withhold life-prolonging measures, particularly if the directives were to acquire statutory sanction, is likely to affect the customary doctor–patient relationship, and particularly the balance of autonomy and dependency between the parties. If the practice were to become general rather than rare and involve asking a relative or friend to sanction or procure an earlier death, it would also in all probability signal a change in the nature of inter-generational, kin relationships.

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References

1 Frazer JG. The belief in immortality and the worship of the dead. London: Macmillan, 1913; Tylor EB. Primitive culture. Researches into the development of mythology, religion, art and custom. 2 Vols. London: John Murray, 1871
9 Porter D, Porter R. (eds) Doctors, politics and society; historical essays. Amsterdam: Rodopi, 1993
28 See, for example, the case of child B denied further treatment for leukaemia on the NHS by the Cambridge Health Authority. The case was extensively treated in the press between 10-15 March 1995
29 Society for the Protection of the Unborn Child (SPUC)
30 Voluntary Euthanasia Society