Article

Culture and Attitudes Towards Euthanasia: An Integrative Review

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Abstract

We examine and integrate last two decades of research on euthanasia from a cultural perspective. After an exhaustive search from Scopus and Web of Science, 40 studies matching our criteria are included in the review. We qualitatively summarize the literature country-wise and use text map of co-occurring terms in the titles, keywords, and abstracts of these articles to determine the similarities and differences among sub-themes in continental clusters. Research done in Asian, European, North American, and multi-cultural studies suggests that attributes unique to each culture are instrumental in shaping public attitudes towards euthanasia. We also find that some cultures, despite the prevalence of euthanasia, are underrepresented in empirical research. This review of literature on the cultural nuances in end-of-life decisions such as euthanasia is pertinent to social scientists, healthcare professionals and social workers in any given time, but more so during such critical events as worldwide COVID-19 pandemic.

Keywords

end-of-life, euthanasia, culture, integrative review, pandemic

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The Greek term "euthanasia" (meaning "good death") is morally polysemous (Altomonte, 2020); previously it meant protecting the bereaved but now it represents a range of actions from poisoning patients to withholding nutrition (Rachels, 1975), creating "moral indefiniteness" (Livne, 2019, p. 256) around its meaning. This review uses the following definition of euthanasia:

> [Euthanasia is] "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated" (Kuhse et al., 2015, p. 236).

Legal and ethical aspects of euthanasia have received media coverage, especially when connected with landmark events; for example, passing the Death with Dignity Act into law (Gonzales vs. Oregon, 2006), legalizing passive euthanasia in India (Aruna Ramchandra Shanbaug vs Union Of India & Ors, 2011), or the recent acquittal of a Dutch physician who administered euthanasia to a dementia patient without informed consent (The New York Times, 2019). However, our review of literature from 2000-2020 indicates the absence of a structured attempt to capture the national cultural nuances influencing euthanasia decisions. This absence becomes conspicuous during pandemic outbreaks like COVID-19 when making life and death decisions become critical for physicians due to such reasons as sudden inflow of patients, shortage of staff and equipment etc. Media reports indicate that during the outbreak, Italian physicians received guidelines to maximize utility of available infrastructure, meaning that some patients received ventilator support while others died gasping for air (Mounk, 2020). Italian physicians are not alone; country-wise stories of the physicians' psychological state in making such decisions abound in global mainstream media (Fink, 2020; Roberts, 2020; Stephens, 2020; Times News Network, 2020). These psycho-social dynamics also interact with the cultural nuances across countries, owing to distinct values, beliefs, and attitudes. Where would social scientists turn to make sense of this piece among the plethora of unprecedented phenomena that COVID-19 pandemic has suddenly ushered the world into?

One theoretical concept that can inform an enhanced understanding of the end of life decisions—for example, the predicament of the physicians, the psychological state of the family members, or the social workers' interventions is 'euthanasia'. However, given that there is no systematic review on the topic, healthcare professionals as well as psychologists and social scientists in general lack a holistic understanding of the research on the topic to be able to inform the ongoing state of affairs. Therefore, we ask: what does research of the past two decades say about the cultural attributes influencing euthanasia decisions around the world? We answer this question through an integrative review (Jackson, 1980; Toronto & Remington, 2020; Whittemore & Knafl, 2005) of

empirical and conceptual studies of the past 20 years related to euthanasia in cultures around the world.

Impetus and Relevance of the Topic

Globalization results in international migration (Rechel et al., 2013) which impacts individuals' access to and utilization of healthcare. Cultural differences among physicians and patients may result in inequality of healthcare delivery (Yilmaz et al., 2017); pandemic outbreaks exacerbate this (Giezendanner et al., 2017) because cultural worldviews may provide different explanations and cures for the illness, causing confusion and stigmatization (Bruns et al., 2020). Scholars argue that collectivist worldviews reduce perceived powerlessness over the pandemic and increase the likelihood of social distancing vis-à-vis individualist cultures (Biddlestone et al., 2020). Lack of cultural sensitivity may also cause unresolved spiritual issues that amplify the pain of death (Givler & Maani-Fogelman, 2020). In unraveling the cultural complexity of euthanasia, our review identifies the intangible factors influencing thousands of patients, families, and physicians who make complex end-of-life decisions worldwide during the pandemic. This integrative review, the first to examine how cultural attributes shape public opinion across multiple worldviews, is timely and relevant; we enable patients, families, and physicians to communicate better on treatment options, resulting in culturally-appropriate end-of-life scare (Givler & Maani-Fogelman, 2020).

Intercultural competence (Fritz et al., 2005) also becomes a crucial factor in ensuring that culturally diverse patients receive non-ethnocentric care, avoid cultural attribution to disease (Kahissay et al., 2017), and make informed decisions (Yilmaz et al., 2017). Since a patient's cultural worldview is the basis of making treatment decisions (Ersek et al., 1998; Mathew-Geevarughese et al., 2019) in modern healthcare settings, our study contributes to scholarly literature by identifying cultural factors contributing to attitude towards euthanasia in major continents.

Theoretical Underpinnings and Terminology

Because euthanasia literature has legal and policy underpinnings, clarity of terminology is important for subsequent discussion. Voluntary active euthanasia (VAE) is the act of a physician intentionally administering medication with the patient's consent to bring about the patient's death (Emanuel, 1994). When the physician performs the same action with the same intention without the patient's consent, the act becomes 'involuntary active euthanasia' (Rigter, 1989). Passive euthanasia occurs when life-sustaining resources are withheld from the patient until death (Emanuel, 1994). Physician assisted suicide (PAS) occurs when a physician provides medication to a patient knowing that the patient intends

to use it to commit suicide (Emanuel, 1994). When euthanasia occurs against the patient's will, it is termed non-voluntary euthanasia (Lewis, 2007), which forms the basis of the 'slippery slope' argument. However, empirical evidence of the slippery slope is scant even in the Netherlands where all forms of euthanasia are accepted (Weyers, 2001); therefore our study is restricted to VAE, passive euthanasia and PAS which have received the most scholarly attention.

Historical Overview of Social Attitude Towards Euthanasia

In Western philosophical thought, public sentiment towards VAE and PAS has been similar to the sentiment towards suicide (Yount, 2000). In *Phaedo*, Plato writes that Socrates accepted hemlock calmly while stating that "true philosophers make dying their profession" (Pence, 2004). Even though the state supported suicide of terminally ill patients at the time, Aristotle termed suicide "an act of cowardice" in *Ethics*. Stoics, on the other hand, upheld a tolerant view towards euthanasia, as documented by Seneca, "*If I know when I will suffer forever, I will depart. Just as I choose a ship to sail in or a house to live in, so I choose a death for my passage from life*" (D. Cox, 1993). As Christianity gained momentum in the West, the attitude towards euthanasia turned prohibitive with St. Augustine, a 5th century bishop, calling it a "detestable and damnable wickedness" (Humphry & Wickett, 1990). This view remained unquestioned for centuries until scholars of the Renaissance and Enlightenment argued that people have the right to control how they die. Hume argued that if an individual was leading a life of serious illness or disability, unable to contribute to society and enduring pain, suicide to end such a life benefits society (Pence, 2004). The efforts of Renaissance scholars received legal validity in the late 19th century.

Post-renaissance, attempts to legalize euthanasia in the early 19th century in the US and the UK were voted down (Humphry & Wickett, 1990). The Nazi government's euthanasia program added an economic dimension to the term as its intention was to avoid government expense to care for "useless" people (Yount, 2000, p. 10). By the 1950s, advances in medical technology increased life expectancy thereby changing the very nature of dying: instead of dying swiftly from infectious diseases, individuals were "rescued" by machines until old age where they suffered from chronic conditions and debilitation (Yount, 2000). As access to education increased by the 1980s, monopoly of doctors on end-of-life decisions declined and civilian-led right-to-die movements emerged (Humphry, 1989; Filene, 1998; Scherer & Simon, 1999). The issue became more divisive, with supporters arguing for patient autonomy (Fletcher, 1987; Rachels, 1975) and death with dignity (Agrawal & Emanuel, 2002) and opposers arguing for the equality of all human lives and the possibility of creating a 'slippery slope' where vulnerable patients are psychologically pressured to die (Yount, 2000). One outcome of this conflict in the US was the passing of the Death with Dignity Act in Oregon in 1994 to legalize assisted dying in the state. The

American model prevails across most of Europe; a notable exception is the Netherlands is where all forms of euthanasia are legal (Griffiths et al., 1998; Van der Heide et al., 2007; Van der Maas et al., 1996). Another exception is Japan, where euthanasia is considered honorable under certain conditions (Tanida, 2000).

Influence of Culture in Shaping Attitude Towards Euthanasia

Death frightens people because of its power to abruptly end everything they hold dear. Our ancestors therefore sought means to transcend death, one of which was creating "cultural worldviews" (Pyszczynski et al., 2010) including explanations for death and associating individual self-esteem with compliance to these worldviews. By reducing mortality salience (Burke et al., 2010), cultural worldviews promise literal and symbolic immortality (Pyszczynski et al., 2010).

Sociologists and anthropologists argue that culture is "the most central problem" of social science (Kroeber & Kluckhohn, 1952; Malinowski, 1939, p. 558). Scholarly literature on culture diverges into three streams: interpretivist (Geertz, 1973), critical (Barnard & Spencer, 1996) and intergroup (Hecht et al., 2005). The intergroup stream focuses on individuals' relationship to groups and argues that culture is manifested through group identification and membership (Baldwin et al., 2006). This perspective is situated in social identity theory (Tajfel & Turner, 1986) which argues that when social identity is central, group beliefs supersede individual beliefs. Accordingly, we define culture as "how people identify with groups, how others identify people as members of groups, how groups define themselves and are defined by others, how groups separate from and/or compare themselves with other groups" (Hecht et al., 2005).

Scholars argue that the Patient Self Determination Act of 1991 assumes variations along four cultural dimensions among diverse patients: autonomy, informed decision-making, control over decisions and candor (Mitty, 2001; Newman et al., 2006). For example, in the US, autonomy is an empowering attribute while in Korea, it is burdensome (Blackhall et al., 1995) because Koreans prefer collective, family-based decision making over individualistic, patient-centered decision making (Newman et al., 2006). Acculturation to an individualistic culture may increase the need for autonomy among members of collectivistic cultures (Hamamura, 2012; Rhee & Jang, 2019); a study of seniors of multiple ethnicities living in New York indicated that they were uncomfortable delegating end-of-life decisions to family (Morrison et al., 1998). Collectivist cultures, on the other hand, impede individual decision making by removing the patient from euthanasia decisions (Blackhall et al., 1995), sometimes not even informing them about impending death (Schwartz, 2004). This, in turn, affects candor; full disclosure of illness to patients is more likely in the US and European cultures vis-à-vis others (Ersek et al., 1998). The lack of candor is

compounded by cultural beliefs against speaking about death (Rhee & Jang, 2019) held by Chinese and Mexicans, among others (Carrese & Rhoades, 1995).

Finally, cultural attitudes towards pain and pain avoidance vary (Newman et al., 2006). Some cultures view suffering as the body's attempt to recover (Post et al., 1996) while fighting against the enemy (Kalish & Reynolds, 1981) while others view it as a cleanser of sins or punishment for misdeeds (Post et al., 1996). For the latter group, pain is a test of faith (Blackhall et al., 1995) and longevity is critical, therefore ending life through euthanasia is unacceptable (Newman et al., 2006). This contradicts the general view of the Western healthcare system that patients should not suffer (Newman et al., 2006).

Method

Search Strategy. Our primary sources of literature were Web of Science (WOS; https://www.webofknowledge.com) and Scopus (http://www.scopus.com) in conjunction with Google Scholar (GS). We chose these sources for two reasons. First, our aim was to capture the breadth of literature around euthanasia; scholars have demonstrated that WOS and GS show poor to moderate overlap of results for similar search terms (Haddaway et al., 2015) indicating larger number of relevant articles. Given the interdisciplinary nature of euthanasia, using search results from these three sources gave us a comprehensive understanding of the landscape while also pointing us to citations not covered by ISI citation databases (Yang & Meho, 2006). Second, despite technical limitations, GS provides greater coverage of non-American journals (Iowa State University, 2020) and books (Haddaway et al., 2015). We searched these databases using the keywords "euthanasia AND culture", "euthanasia AND cultural" and "euthanasia AND cross-cultural", limiting our search to studies in peer-reviewed journals in English, published between 2000 and 2020. This gave us an initial list of 963 articles.

Study Selection. Since our study focuses on the cultural aspects of euthanasia, articles focusing solely on human physiology or related to animal euthanasia were removed at the outset. We reviewed the list of journals in which articles were published to exclude those that are not peer-reviewed. Similarly, books that provide overview of the euthanasia debate were excluded, as were duplicates from WOS and GS results. From this list, we identified relevant articles in two phases. In the first phase, we reviewed the title and abstract of each article and included in our list empirical studies of euthanasia decisions made from the standpoint of one or several cultural worldviews. This was followed by papers making only passing references to culture, for example, risk of abuse or philosophical papers, and generic articles on the need for cultural competence. 40 articles remained, which we sorted in decreasing order of citation count to determine which articles most influenced the evolution of the literature.

In the next phase, we reviewed the references of the highly cited articles to identify any relevant articles we may have overlooked. We studied the full text of all the articles and excluded those focused solely on policy implications and those with only passing reference to culture. We segregated empirical studies by continent; multicultural studies were categorized separately. To decrease bias, both authors reviewed every item on this final list and jointly decided on the eligibility of each article. The PRISMA diagram (PRISMA, 2020; Whittemore & Knafl, 2005) in Figure 1 summarizes our literature identification process.

Data Extraction, Qualitative Summary, and Text Mapping of Cooccurring Terms. The first author prepared a data extraction spreadsheet including the following information related to every article included in the study: *(a) title of the study, (b) author(s), (c) year, and (d) relevant findings*. We then qualitatively summarized the studies. Because another objective was also to identify thematic categories in the interaction between culture and attitude towards euthanasia, we created a continent-specific text map of co-occurring terms in the titles and abstracts of these articles to determine the similarities and differences among sub-themes worldwide. For this we used VOS viewer, a software tool designed by

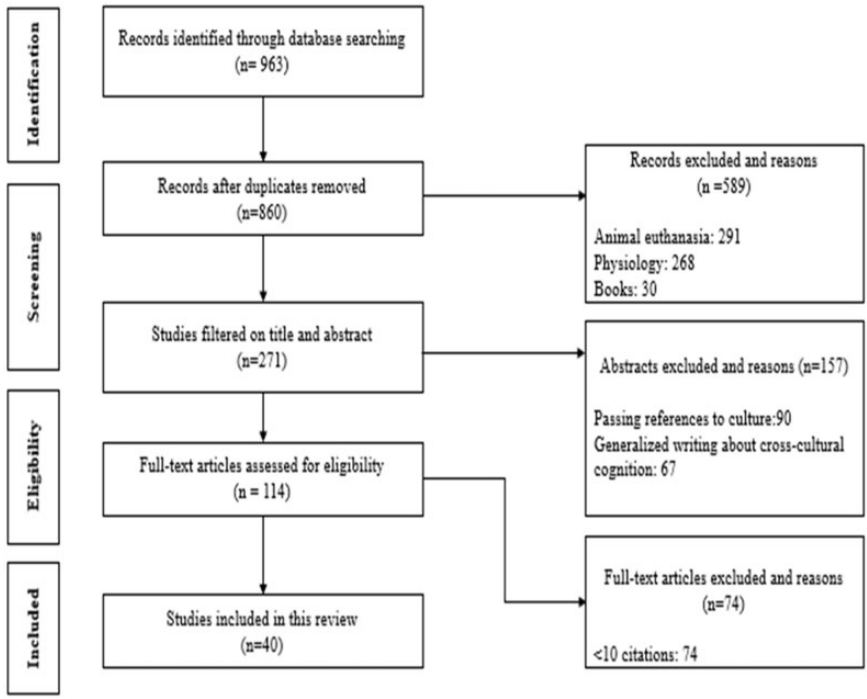

Figure 1. PRISMA Diagram Indicating the Identification of Eligible Articles for This Study.

researchers at Leiden University to analyze and visualize bibliographic networks (Van Eck & Waltman, 2019). This tool identifies bibliographic coupling among publications, co-authorships, and cooccurring linkages among keywords. Well-linked keywords are grouped into clusters providing a visual representation of the landscape of the literature. Using network, overlay and density visualizations, the tool gives researchers insights on linkages among clusters, historical evolution of the literature, and the weightage of each cluster.

Results

Search Results

Our initial search yielded 963 unique articles as shown in Figure 1, of which 40 articles were finally included in our study. As indicated in the VOS viewer diagram in Figure 2, ten themes emerged from the analysis of titles and abstracts of the articles included in our study. These were *(a) attitude, (b) belief, (c) death, (d) suicide, (e) culture, (f) life, (g) country, (h) physician, (i) palliative care, and (j) patient*. Since we found that the conceptualization of euthanasia, belief systems and attitude towards death varied substantially among continents while

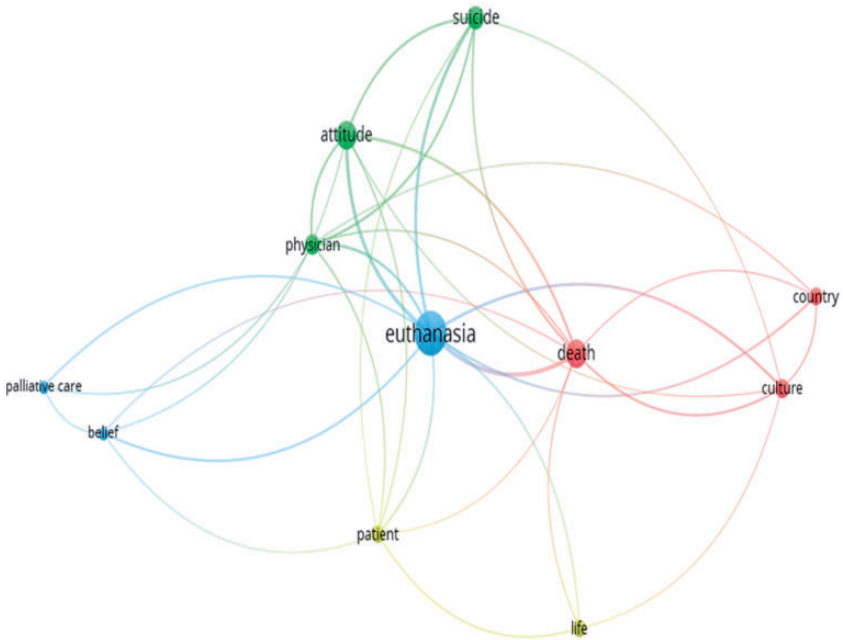

Figure 2. Text Mapping of Cooccurring Themes Identified in Titles and Abstracts in All 40 Studies.

remaining similar among countries within the same continent, we segregated our findings at this level.

Note. The diagrams are drawn using Vos viewer (www.vosviewer.com) The size of the fonts and circles indicate the importance of the term within the literature. Terms belonging to similar clusters have the same color. Lines between items represent linkages between the themes.

Studies Segregated By Continental Clusters. *Asia*. As shown in Table 1, our list included eight studies from Asia: three studies from China, two from Japan, one each on HK, Iran, and Turkey. The key takeaway from these studies appears to be public opposition to euthanasia. Analysis by VOS viewer in Figure 3 indicates the cultural subthemes based on title and abstract.

Chinese culture is polylithic (Bowman & Singer, 2001; Payne et al., 2005), meaning that it comprises of mutually coherent but heterogeneous regional subcultures (Meyerson & Martin, 1987). Attributes of collectivist Asian cultures including Chinese, Japanese, Turkish and Iranian (Bochner, 1994; Hofstede, 1980, 2001) include filial piety (Unschuld & Unschuld, 1979), collective decision making, hierarchy, paternalistic approach towards doctors (Hayashi et al., 2000), and maintaining social order and restraint (Payne et al., 2005). Contrary to Western countries, multiple religions are practiced in pockets (Yang & Lang, 2011) and these enmesh with philosophical traditions to determine attitude towards euthanasia (Da Pu, 1991; Hsu et al., 2009). For example, the fatalistic attitude to death (Yang & Chen, 2002) adopted by the Chinese, believing that early or painful death is the consequence of former misdeeds (Mjelde-Mossey & Chan, 2007) aligns with the Hindu belief in 'karma' where every action elicits a result (Hardt, 1979) and the Arab belief in the *Maktub* that the duration of life is predetermined by God. This aligns with the Durkheimian view that fatalism is present in societies that control their members excessively (Cox, 2005). Added to these are beliefs whose origins may have been religious but are now validated by an entire culture, such as talking about death bringing bad luck (Mjelde-Mossey & Chan, 2007).

Given their interdependent self-construal (Markus & Kitayama, 1991), patients from Asian cultures may devalue autonomy, instead delegating decision making to family (Barker, 1992) and aiming to achieve social cohesion (Payne et al., 2005). In Japan, being '*wagamama*', translated as autonomous, is considered contrary to goodness, representing exclusion that is their worst "cultural nightmare" (Plath, 1980, p. 217; Traphagan, 2013). Scholars argue that the meaning of euthanasia continues to be ambiguous in Japan and that the existence of multiple narratives may diffuse public opinion on whether the deed is honorable (Traphagan, 2013). One such example is Hayashi et al. (2000) where Japanese participants reported that in situations of medical extremity, autonomous decision making was honorable because it led to death with dignity while

Table 1. List of Studies From Asia.

Reference	Method	Sample size	Country	Relevant results
Karaahmetoglu & Kutahyalioglu (2019)	Survey	1170	Turkey	Majority opposed euthanasia, results varied based on age, gender & area of study
Bowman & Singer (2001)	Interviews	40	China	Respondents' attitude to euthanasia aligned with their religious views
Payne et al. (2005)	Literature review	NA	China	Patients preferred to be informed of their prognosis along with families & prefer intensive care over euthanasia. This society exists as smaller pockets of subgroups that must be individually considered.
Yang & Chen (2002)	Phenomenography	239	China	Younger children visualize death as a biological event while older children give it a metaphysical interpretation
Mjelde-Mossey & Chan (2007)	Survey	430	HK	Respect for dying process based on religious views & ingrained processes to ward off bad luck. Beliefs align with those of other religions like Hinduism & Islam
Aghababaei (2014)	Survey	190	Iran	Individuals high on conscientiousness & altruism opposed euthanasia
Traphagan (2013)	Conceptual	NA	Japan	Autonomy & independent decision making are considered selfish and antithetical to Japanese culture
Hayashi et al. (2000)	Survey	861	Japan	Euthanasia is honorable & permissible under certain conditions. Mixed responses regarding paternalistic approach towards doctors.

for attempted suicide, it was not. Increasing patient autonomy also indicated a decrease in paternalistic approach towards physicians.

Other cultural factors influencing the attitude towards euthanasia in Asia include altruism and conscientiousness. Altruistic individuals are unwilling to

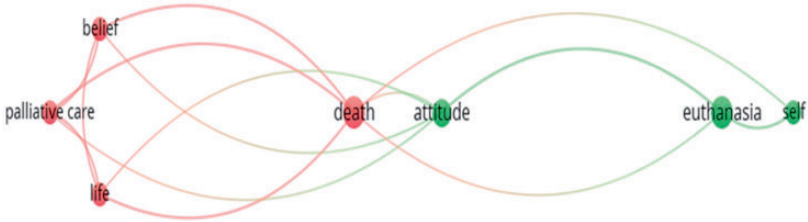

Figure 3. Text Mapping of Cooccurring Themes Identified in Titles and Abstracts in Asian Cultures.

harm others (Aghababaei, 2014) while conscientious individuals adhere to social norms (Ashton & Lee, 2007). A study of Iranian students by Aghababaei (2014) found that conscientious individuals perceived actions resulting in the death of others as violating religious, social and ethical norms, and opposed it. Similarly, altruistic individuals, especially women, adopted a pro-life stance. A contradictory finding was observed in a study of students in Turkey (Karaahmetoglu & Kutahyalioglu, 2019), a country similar to Iran with respect to religion and law. Here scholars found that students of healthcare and law supported euthanasia while those from other disciplines opposed it. This dichotomy indicates the need for deeper study of demographic characteristics and environments influencing the attitude towards euthanasia.

Religion appears to be a significant influencer of attitude towards euthanasia in Asian cultures by defining what constitutes a meaningful life. For example, Confucianism, by virtue of Zhongyong thinking (Yang et al., 2016) and assertion of an afterlife, attributes less importance of the act of dying and higher priority to creating a meaningful life through righteous action (Hsu et al., 2009; Qin & Xia, 2015). Taoism similarly asserts the existence of an afterlife, delegating death as a phase of life (Kleeman, 2003). Taoists believe in the importance of balance in life, encouraging believers to sustain life through any means possible (Qin & Xia, 2015). Mahayana Buddhism espouses principles akin to Confucianism (Qin & Xia, 2015).

Europe. As shown in Table 2, our list included sixteen studies from Europe. Of these, the majority was from the Netherlands, followed by UK and other European countries. The key takeaway from these articles appears to be the lack of consensus among European countries around the meaning of euthanasia (Gysels et al., 2012) and subsequently, the plurality of attitudes towards it. Analysis by VOS viewer in Figure 4 indicates the cultural subthemes based on title and abstract.

The Unique Stance of the Netherlands. Netherlands is part of the Belgium-Netherlands-Luxemburg (Benelux) trio, European countries where euthanasia is legal. The Netherlands led Europe in the journey towards death with dignity

Table 2. List of Studies From Europe.

Reference	Method	Sample size	Country	Relevant results
(Cuttini et al., 2000)	Survey	1235	Luxemburg, Netherlands, Sweden, France, Germany, Italy, UK, Spain	Most physicians took end-of-life decisions for children, mostly through passive euthanasia. Age, experience & religion influenced this.
Seale (2006b)	Survey	857	UK	Passive euthanasia preferred by UK doctors based on a philosophy of palliative care.
Gysels et al. (2012)	Literature review	NA	Germany, Norway, Belgium, Netherlands, Spain, Italy, and Portugal	End-of-life care has different meanings across countries based on national culture & professional experience of physicians
Menaca et al. (2012)	Literature review	NA	Spain, Italy, and Portugal	Similarities include low levels of euthanasia decisions; religion & strength of family ties influence this.
Evans,Meñaca, Andrew, Koffman, Harding, Higginson, & Gysels, (2012)	Literature review	NA	UK	Minority communities in the UK receive suboptimal medical care; ambiguity exists around the meaning of culturally competent care
Evans, Bausewein, Menaca, Andrew, Higginson, Harding, & project PRISMA (2012)	Literature review	NA	Germany	Physicians and patients are aware of advance directives & use them. Low use among general population
Evans, Meñaca, Andrew, Koffman, Harding,	Literature review	NA	UK	Policy for end-of-life care for minorities needs to be strengthened.

(continued)

Table 2. Continued.

Reference	Method	Sample size	Country	Relevant results
Higginson, & Gysels (2011)				
Van Wijmen et al. (2010)	Survey	1621	Netherlands	Respondents were aware of euthanasia legislation, however, many of them did not prepare advance directive for religious reasons
Seale (2006a)	Survey	857	UK	Doctors cautious about administering active euthanasia, but willing to discuss decisions with family and colleagues
Herman (2006)	Conceptual paper	NA	Netherlands	Origins of the gidsland tradition from the Dutch drive for humanitarianism
Solarino et al. (2011)	Survey	1	Italy	Absence of clear legislation results in Italian physicians having the least experience across Europe in taking EOL decisions
(Mystakidou et al., 2005)	Conceptual paper	NA	Greece	Attitude towards euthanasia has evolved temporally. Change in family structure has resulted in increased isolation and institutionalization of the elderly.
Weyers (2006)	Conceptual paper	NA	Netherlands	Acceptance of euthanasia is facilitated by layers of control including physician, patient family, third parties and the government
Chambaere & Bernheim (2015)	Conceptual paper	NA	Benelux	Legalization of euthanasia has not decreased focus on palliative care, it has increased it
Andrew et al. (2013)	Literature review	NA	Belgium	Sociocultural factors impacting euthanasia decisions include Catholic affiliation, patient autonomy, trust
Cohen-Almagor (2001)	Interviews	28	Netherlands	Most respondents denied the existence of a 'culture of death' in the Netherlands

Figure 4. Text Mapping of Cooccurring Themes Identified in Titles and Abstracts in European Cultures.

by legalizing of all forms of euthanasia in 2002. Belgium legalized an integrated palliative care model including euthanasia in 2002 (Bernheim et al., 2008) and Luxemburg followed suit in 2008 (Gysels et al., 2012).

A nationwide Dutch study (Van der Maas et al., 1991) indicated that 17.5% of all deaths were attributable to physicians administering opioids in doses sufficiently high to cause death and another 17.5% to discontinuation of treatment. Some unique attributes of the Netherlands make this possible: free universal healthcare, homogeneity in social class resulting in similar points of view, long-term doctor-patient relationships and the ability to discuss contentious issues calmly while complying with regulations (Yount, 2000). Following the Dutch model, non-physician assisted suicide has been legalized in Switzerland (Hurst & Mauron, 2003) where the right-to-die organization Dignitas (http://www.dignitas.ch/) promotes "suicide tourism" (Gauthier et al., 2015) by providing lethal prescriptions to visitors meeting specific criteria (Yount, 2000).

The Dutch approach of acceptance towards euthanasia was evident in the articles identified for our study. Advance directives where patients detail their preferences about end-of-life treatment are also legal in Dutch society, empowering physicians to end patients' lives under certain conditions (Van Wijmen et al., 2010). This liberal attitude of the Dutch may be attributed to the *gidsland* principle, a consequence of Dutch foreign policy by which the Netherlands considers itself to be a global benchmark on humanistic issues (Herman, 2006).

This liberal attitude characterized by openness to discussions of death and the frequency with which terminally ill patients request euthanasia have created an international reputation of the Dutch "culture of death" (Cohen-Almagor, 2001), but local experts argue that euthanasia is a "system to help people in their time of need" (Cohen-Almagor, 2001, p. 176) and are unanimous in accepting it (Cohen-Almagor, 2001). Some scholars attribute openness to the Dutch culture of candor (Kennedy, 2002), resulting in faster denigration of taboos (Weyers, 2006). As technology advanced sufficiently to be able to prolong life, the Dutch responded by interpreting the cessation of futile treatment as the duty of a physician (Weyers, 2006). Moreover, the Dutch demonstrate higher post-

materialistic value orientation than most countries (Inglehart, 1997; Norwood, 2007), meaning they value autonomy in physiological matters like euthanasia (Elchardus et al., 2000). Legal provisions give patients control over doctor-patient relationships through autonomous decision-making based on the quality of their lives (Heide, 2003). Therefore, by enveloping euthanasia decisions in three layers of control: physician, patient and state, an informed request from a patient undergoing unbearable suffering receives legal support for euthanasia (Weyers, 2006).

Although opposers of legalized euthanasia warn about potential abuse through the slippery slope argument, our review indicated no such evidence. For example, a comparative study on the development of palliative care in Benelux vs other European countries indicated that contrary to expectation, permissiveness of euthanasia increased the development of palliative care (Chambaere & Bernheim, 2015). A similar result was found in a study focusing on Belgium, a country with robust palliative care and euthanasia frameworks (Andrew et al., 2013). The study also found that despite patient and physician autonomy, end-of-life decisions were based on trust built on strong doctor-patient relationships. Trust could also be the reason behind the usage of lethal medication on compassionate grounds for patients with unbearable suffering (Andrew et al., 2013; Deliens et al., 2000).

Approach of Other European Countries. Studies from other European countries indicate opposition towards euthanasia, based on local sociocultural factors. For example, although PAS is legal in Germany, the culture is less accepting of its practice due to the country's secular and individualistic outlook and memories of the Nazi regime (Cohen et al., 2006). Similar opposition is evident in studies from Norway where most physicians adopt conservative attitudes towards euthanasia, and cultural respect of the law prevents physicians with liberal attitudes from practicing it (Førde et al., 2002). In Spain, physicians are uncomfortable delivering bad news to patients and conform to the 'conspiracy of silence' imposed by the patients' family, so patients are unable to make euthanasia decisions (Rio-Valle et al., 2009). Italy and Portugal, countries with the lowest acceptance rates of euthanasia in Europe (Menaca et al., 2012), are characterized by lack of awareness about palliative care (Cohen et al., 2006). In a study of over 22,000 Italian physicians providing end-of-life care, 42% rated themselves incapable and 8% unsure of helping patients take euthanasia decisions (Solarino et al., 2011), despite the existence of official guidelines legalizing passive euthanasia.

Cultural differences among European countries were also evident in a study of EOL practices followed by physicians in the UK (Seale, 2006b) which indicated that the culture of UK resembled that of countries permitting euthanasia with respect to delivering bad news to patients and discussing end-of-life options with colleagues, but aligned better with non-permissive countries when taking

Table 3. List of Studies From North America/Europe-America.

Reference	Method	Sample size	Country	Relevant results
Emanuel et al. (2016)	Poll data & published surveys	NA	USA, Europe	<5% physicians comply with requests for active euthanasia in states where it is legal. Practice is more widespread in Europe
Verbakel & Jaspers (2010)	Published surveys	NA	USA, Europe	Religious people, minorities, and low-income groups more likely to oppose euthanasia. People in cultures valuing autonomy are more likely to support euthanasia
Moselli et al. (2006)	Literature review	NA	USA, Europe	Differences in end-of-life decisions taken in US and Europe may be attributed to social and cultural differences. Even in autonomous cultures, dying patients may prefer collective decision making because they may be emotionally overwhelmed
DeCesare (2000).	Published surveys	NA	USA	Americans' approval of euthanasia increased over the past two decades. Race, religious commitment & religious attendance are significant predictors of euthanasia approval.
Joseph (2005)	Historical analysis	3	USA	Current proposals supporting euthanasia may be based on (Kennedy, 1942) and this may result in such theories being proposed in future.
Moulton et al. (2006)	Published surveys	NA	USA	All religious groups have liberalized their stance on euthanasia over time in varying degrees.
Sklansky (2001)	Conceptual paper	NA	USA	Legal & moral permissibility of neonatal euthanasia continues to be debated in the medical community

(continued)

Table 3. Continued.

Reference	Method	Sample size	Country	Relevant results
Duncan & Parmelee (2006)	Published surveys	NA	USA	Americans' approval of euthanasia has increased since 1970s and now levelled.
Allen et al. (2006)	Published surveys	NA	USA	Americans' approval of euthanasia has increased since 1930s.
Appel (2004)	Historical analysis	NA	USA	Euthanasia was common medical practice in the early 19th century for practical reasons; it was controversial because of its association with eugenics.
Brockopp (2008).	Conceptual paper	NA	USA	Traditional notion of the human person in Islam is changing considering technology advancements. Religion continues to influence euthanasia decisions by legitimizing ethical responses
Jones (2011)	Conceptual paper	NA	USA	Slippery slope exists from voluntary to non-voluntary active euthanasia. They should be accepted or rejected together.

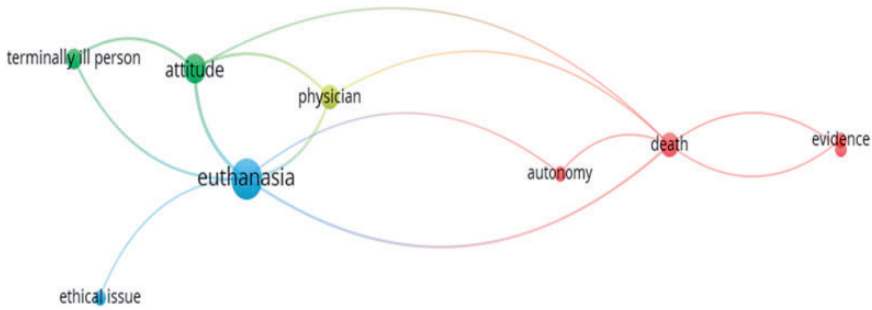

Figure 5. Text Mapping of Co-occurring Themes Identified in Titles and Abstracts in American Culture.

decisions relating to shortening life and reporting such decisions. A similar survey of UK physicians indicated that PAS was relatively low in the UK vis-à-vis other European countries (Seale, 2006a). This contrast could be attributed to a collaborative approach adopted by physicians towards end-of-life decision making while protecting themselves from administrative scrutiny, a time-honored attribute of the British medical culture (Seale, 2006a). The decrease in PAS could be attributed to rapid development of palliative care in the UK (Seale, 2006b), increasing physicians' awareness and sensitivity to pain-free survival of patients.

North America. As listed in Table 3, this category comprised of twelve articles exclusively from the USA. Analysis by VOS viewer in Figure 5 indicates the cultural subthemes present in the literature based on title and abstract.

Traditionally, scholarly literature on euthanasia has been US-focused and this may be attributed to the development of standard end-of-life guidelines in the US healthcare system (Moselli et al., 2006). According to medical historians, documented debates on euthanasia featuring prominent physicians of the time occurred in the US as early as 1906 (Appel, 2004). Although supporters argued from the viewpoint of reducing suffering, opponents who highlighted the contradiction of this practice with the American tradition had the upper hand. Historians argue that eugenic sterilization, designed to kill unauthorized genes, was legalized in the US by 1930 (Black, 2003) as a forerunner to killing the carriers of such undesirable genes through euthanasia (Joseph, 2005). Euthanasia has been legal in five states in the US since the early 2000s and requests are granted after careful consideration (Emanuel et al., 2016). Multiple studies demonstrate a positive public attitude towards euthanasia: a study based on the World Values Survey indicated that approximately half the population approved of euthanasia (Verbakel & Jaspers, 2010) while DeCesare (2000) found that the proportion of the American population favoring euthanasia increased by 8% between 1977 and 1994. A consolidation of opinion polls

about public attitude towards euthanasia over decades showed an overall increase in support (Duncan & Parmelee, 2006) and these results are aligned with DeCesare (2000) and Allen et al. (2006).

This attitude towards euthanasia may be attributed to several cultural factors unique to the US. The first is the combination of declining trust in public institutions including healthcare and the increase in patient autonomy (DeCesare, 2000). According to Humphrey and Clement (2000), Americans' trust in healthcare declined from 73% in 1966 to 23% in 1994, manifesting as the increased popularity of right-to-die movements (Hoefler, 2019) and the existence of documented guidelines for euthanasia decisions. The ambiguity on neonatal euthanasia notwithstanding (Sklansky, 2001), scholars attribute the focus on such specific guidelines to business-like pragmatism with clear instructions, roles and responsibilities, and resource allocation (Moselli et al., 2006). Similarly, the priority for individual autonomy may be attributed to the shift towards secular behavior and decreased religious control (Hamil-Luker & Smith, 1998), resulting in a system where patients or proxies are given equal right in end-of-life decisions as physicians (Moselli et al., 2006). An interesting paradox, however, is that while people distrust healthcare, they are more approving of euthanasia than of suicide, thereby increasing the importance of doctors' participation in end-of-life decision making (DeCesare, 2000).

Given the rich cultural and religious diversity in the US, the roles of religion and religiosity in shaping public attitude towards euthanasia warrant further explanation. A study of terminal cancer patients in the US indicated that the intensity of symptoms played a limited role in decisions around VAE or PAS; instead, the significant influencers were religiosity and the disappointment of burdening their families (Suarez-Almazor et al., 2002), making atheists more likely to choose PAS over religious individuals. Although religion continues to influence individual attitudes, religions themselves have been liberalizing their stance towards euthanasia over the past four decades (Moulton et al., 2006). For example, an analysis of Islamic scholarly work (Brockopp, 2008) finds that despite conservative underpinnings, the definition of the human person is changing in Islam due to technological advancement and that the role of religion is shifting towards legitimizing ethical responses to end-of-life decisions. Despite the plurality of religious views, scholars find no evidence of mass polarization of public attitudes using religion (Moulton et al., 2006).

Multicultural studies. As shown in Table 4, our list included four studies focusing either on multicultural groups, such as Chinese Americans or comparing attitudes between cultures. Figure 6 indicates the VOS viewer analysis of cultural subthemes covered in these studies.

Studies involving multiple cultures demonstrate that cultures are non-linear entities that do not always advocate well-defined attitudes towards euthanasia (Schweda et al., 2017). Attitude is shaped by the context in which an individual is located and may include sociopolitical and existential concerns. The

Table 4. List of Multicultural Studies.

Reference	Method	Sample size	Country	Relevant results
Hsiung & Ferrans (2007)	Conceptual paper	NA	China & US	Cultural factors influencing end-of-life decisions for Chinese Americans include acculturation, Confucian ethics, collectivism, male paternalism, filial piety, Confucian propriety, and physician paternalism.
Feser & Bernard (2003)	Survey	23	China & Canada	Inability to speak local language can impact the quality of end-of-life care received. Translating assessment tools and educating communities on the benefits of using them may help to increase quality of care received.
Schweda et al. (2017)	Focus group discussions	82	USA, Germany & Israel	Attitude towards euthanasia is not based merely on national culture or religion, but on the situatedness of those beliefs within a family, community, or national context.
Wasserman et al. (2016)	Survey	321	Iran & USA	American students demonstrated pro-euthanasia stance vis-à-vis Iranian, based on honesty-humility, openness to experience and agreeableness

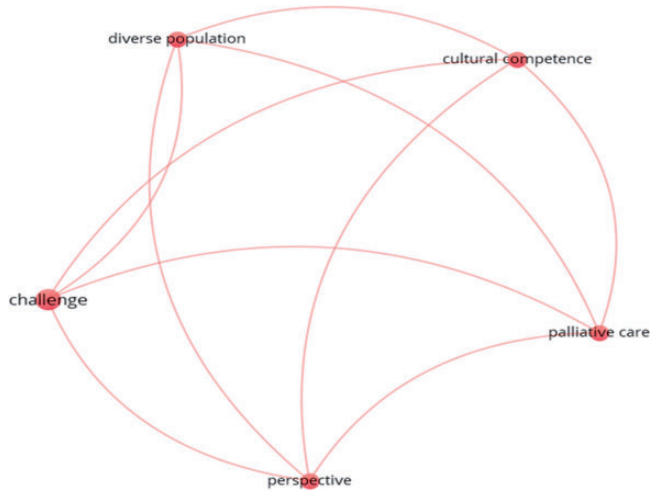

Figure 6. Text Mapping of Cooccurring Themes Identified in Titles and Abstracts in Multicultural Studies.

complexity of culture and the reflexivity of modern cultural attitudes make prediction of individual attitudes almost impossible (Schweda et al., 2017). Reflexivity may arise from individuals positioning themselves with respect to socially expected commitments by accepting, reinterpreting or abandoning them (Schweda et al., 2017). One example of such reflexivity is a study of two generations of Chinese Americans (Byon et al., 2017). While members of both generations in this study agreed on the need for advance care planning, the younger generation articulated greater comfort in discussing it with their peers. However, they did not initiate these conversations with parents for fear of upsetting traditional values of filial piety. The older generation, on the other hand, wanted to inform the younger generation of their wishes but refrained from doing so, expecting that it would make them uncomfortable. Some scholars argue for the need to integrate bioethics with contemporary theories of culture so that end-of-life decisions are made while being mindful of the individual's unique circumstance (Hsiung & Ferrans, 2007; Kramer, 2000; Turner, 2005).

Another example of attitudinal reflexivity was demonstrated in a comparative study of Iranian and American students (Wasserman et al., 2016). Both groups agreed that end-of-life decisions were moral issues, but the American sample was more positive in their attitude towards euthanasia than Iranians. This may be attributed partly to the open discussions around euthanasia in American media. The data also indicated that morality in the US was less connected to religion than it was in Iran. When making practical decisions,

both groups appeared to be less driven by personality and more by convention; those more likely to deviate from convention were likely to hold pro-euthanasia attitudes. Similar reflexivity was demonstrated in a study of Buddhist monks in Canada (Larm, 2019) who supported euthanasia under certain conditions, even in opposition to their vows, because they believed that not disrupting a patient's agency and viewing each patient as unique was more important than moral correctness. Geographic location also appears to be an influencing factor of reflexivity in attitude, as demonstrated in a study of elderly Chinese living in Canada (Feser & Bernard, 2003). Contrary to the Chinese cultural stereotype of withholding death-related information, over a third of participants indicated that they would prefer to be informed by the physician should they face an end-of-life decision. The authors suggest that this change in attitude may be the influence of the Western cultural attitude of candor.

Discussion. This integrative review explored the role of culture in shaping the attitude to euthanasia around the world. Our study contained 40 eligible articles overall. We summarized the literature as well as identified the cooccurring themes in the articles.

Our review indicates that cultural worldviews of physicians, patients, and patients' families, influence belief systems around death and subsequently, attitudes towards euthanasia. More nuanced differences emerged when we mapped the text of the cooccurring themes in the titles and abstracts of published research and reviewed contents in-depth: for example, patients in Asian cultures seek meaning in life and death. This may be the influence of Asian religions like Hinduism and Buddhism that advocate meaning deeper than everyday transactions and seek to transcend death by ascribing a higher level of consciousness to the act of living. Our review indicates that passive euthanasia is permitted and practiced in Asian cultures; although preservation of life through palliative care may be preferred, committing suicide may be considered honorable under certain circumstances.

An interesting observation in the text map from Europe is the absence of the term suicide. European countries hold contradictory cultural worldviews resulting in a plurality of stances towards euthanasia, as shown by the lack of a common attitude across the continent. Benelux countries permit euthanasia by prioritizing patient autonomy over everything else while UK prioritizes caution over autonomy. The USA appears to take an intermediate stance. Being an individualist culture, they prioritize patient autonomy but they are also mindful of the ethical challenges posed by the logical slippery slope from voluntary to non-voluntary euthanasia; therefore, they adopt a pragmatic approach requiring evidence-based decision making throughout the process. In multicultural settings, diversity of populations and cultural beliefs pose challenges to healthcare professionals and call for deeper understanding of cultural competence among healthcare providers. End-of-life decisions are influenced by belief systems of

patients which may vary depending on the level of acculturation (Mills et al., 2017; Tsai et al., 2000) and access to palliative care in a foreign culture.

This review demonstrates the role played by culture in shaping attitudes adopted by policy makers, healthcare professionals and citizens towards euthanasia. It emphasizes the need for cultural competence and sensitivity when making medical or legislative decisions regarding end-of-life care. Further it demonstrates heterogeneity across cultures, and even among subgroups within the same culture. We also find that over the past two decades, several cultures remain underrepresented in the literature: for example, our literature search gave us no eligible studies focusing on Latin American or South American populations. On the other hand, countries such as the Netherlands had many more empirical articles.

Besides integrating the research of the last two decades on euthanasia from the cultural lens, our review also provides a way to reconcile certain paradoxes in the euthanasia debate in society. The multifaceted nature of the euthanasia debate has perplexed scholars for decades: in *Notebooks*, Wittgenstein (1984) made two contradictory remarks "*for suicide is, so to speak, the elementary sin . . . or is even suicide in itself neither good nor evil?*". Wittgenstein argued that fearing death indicated the existence of a poor will but seeking death through suicide was the surest sign of it (Royal Institute of Philosophy, 1974). Our review also revealed contradictory ethical perspectives and we found terms like 'dignity', 'patient autonomy' and 'slippery slope' used by scholars on either side. We believe that these terms are vaguely defined, leaving them open to scholarly interpretation. For example, the slippery slope debate was initiated by a proposal to decriminalize euthanasia (Williams, 1957) as a step towards liberalism and opposed through the utilitarian argument that decriminalizing even one form of euthanasia would lead society down a slippery slope of abuse (Kamisar, 1957). Policymakers continue to use this debate to determine their governments' stance on euthanasia, but these decisions are seldom data-driven (Jones, 2011). Fundamentally, the euthanasia debate appears to be many scholars out-arguing each other on the merits of their chosen stance (Jones, 2011).

One way to make sense of such contradictory arguments may be through the lens of cultural attributes. In doing so, scholars allow for the localization of attitudes towards euthanasia and can better predict how public opinion may shift over time based on sociodemographic considerations and the embeddedness of cultural beliefs within a group. For example, individualistic cultures are more likely to value autonomy and take a pro-euthanasia stance while collectivistic cultures are more likely to comply with the physician's decision, delegating difficult decisions to them. Similarly, in cultures with high levels of religiosity, morality may be tied closely with conformity, resulting in a pro-life stance while in other cultures where people are secular and define morality differently (Vauclair et al., 2015), a pro-euthanasia stance may be adopted. Non-participation in the debate is not an option: recent attempts towards

studied neutrality by palliative care professionals have been criticized by both supporters and opposers of euthanasia, as political interests require taking and supporting one stance (Johnstone, 2012). Studies indicate that national contexts may partially minimize the difference in attitudes towards euthanasia among groups within the same country, possibly explaining why scholars on either side of the debate question the beliefs of opponents from other cultures (Verbakel & Jaspers, 2010). These are but two of the several commonalities we found in our review, indicating that attitudes towards euthanasia are shaped by cultural context.

Our review is limited in a few ways. We chose one definition each for euthanasia and culture during our literature search and given the varied definitions of either construct, we may have precluded several other eligible studies, resulting in a narrow understanding of the role of culture in shaping attitudes towards euthanasia. Within the quantitative studies included in this review, different scales were used to measure attitudes and their influencing factors, limiting the comparability of their results. We combined this with qualitative studies having smaller sample sizes and conceptual papers by euthanasia scholars across cultures. We adopted this approach from our intention to be inclusive because, to our understanding, this is the first integrative review exploring the relationship between cultures and attitude towards euthanasia, therefore we wanted to capture as many studies as possible.

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