Human Justification for Euthanasia An empirical analysis using World Values Survey

Dr. KarwanDhahirSaber[1]& Dr. Sultana Begum[2]

Tishk International University 2022
[1]Law Lecturer, Department Of Business and Management, Faculty of Administrative Sciences and Economics, Tishk International University, Erbil, Kurdistan,karwan.uk@tiu.edu.iq
[1]Asst. Professor, [1]Department Of Business and Management, Faculty of Administrative Sciences and Economics, Tishk International University, Erbil, Kurdistan,sultana.begum@tiu.edu.iq

Abstract
The word 'euthanasia' comes from Greek roots that indicate 'dying well' or 'good death.' The word was first used by Greek poets around 400 BC, and it was then adopted by Greek and Roman philosophers and historians to refer to a death that occurs suddenly and without considerable and prolonged pain. Today, the phrase is mostly used to describe actions taken by others to make dying more bearable. The goal of this study is to look at euthanasia, the physically-assisted death,froma human perspective and explore the variance based on Gender, Age, Education, and Religion of the respondents of the seventh wave of the world values survey. The total respondents from the fifty-one (51) countries, where N= 73,873are taken for analysis for this paper, among which 47.5% are male and 52.4% are female respondents. The researchers want to show that the arguments against the morality and legalization of assisted suicide are stronger than those in favor. Although in many ways our societies have become increasingly secular and detached from religious traditions, the paper discusses both ethical issues surrounding euthanasia and research on the practice of euthanasia as it evolves. It specifies four interpretations of 'euthanasia' namely gender, age, educa,in and religion to arrange the discussion. Mann-Whitney U Test and Kruskal Wallis Test are used to explore the variance. Some of the findings include that there is significant ant variance from the perspectives of the respondent's Age, Education, and Religion but no variance based on gender. Religious perspectives and human justifications for euthanasia are all explored to determine whether there is any connection between them, followed by a conclusion based on data analysis. The paper attempts to contribute to the field of study, euthanasia, which is always a matter of discussion and argument.

Keywords: Euthanasia, Gender, Education, Age, Religion, Variance

1. Introduction:

'Euthanasia' originally meant 'good death' in Greek (euthaeutos). The word was first used by Greek poets around 400 BC, and it was then adopted by Greek and Roman philosophers and historians to describe a death that occurs suddenly and without considerable and lengthy pain (Lewy G 2011)The term 'euthanasia' was not used to describe any medical or non-medical intervention used to hasten a patient's death or relieve his or her suffering. However, since helping a patient's suicide was clearly forbidden in the so-called Hippocratic oath, such involvement cannot have been prevalent in antiquity. however, the concept's meaning has shifted significantly in recent times (D. Birnbacher2011). Many people believe that euthanasia is a form of assisted suicide and that it might be used as a cover for murder. Others have argued that hastening a patient's death is not the most effective technique to alleviate pain.

DOI: 10.9756/INT-JECSE/V14I3.162

Euthanasia, on the other hand, is against medical ethics, is against most religions, and is not the ultimate solution to stop a patient's suffering, regardless of their physical condition. A code of ethics governs the practices of physicians and doctors. Euthanasia is a direct violation of the medical oath, which states that physician-assisted suicide, or dying with dignity, provides people with a unique opportunity to reflect on their lives, make amends for wrongs committed, provide for the future security of loved ones, and mentally and spiritually prepare for their own death (Hiscox, W. E. 2002). Therefore, many individuals and scholars believe doctor-assisted suicide is not only illegal, but also unethical. It is obvious from the following data that doctors who commit these crimes have broken many of the principles and values they pledged to uphold when they became doctors. They have disobeyed every moral value they swore to uphold when they decided to become doctors. A doctor's job is to save a patient's life at all costs, not to help them die. Doctors who help patients commit assisted suicide have broken the Hippocratic Oath, which every doctor must swear to before receiving his license to practice (Unnamed 1976). On the other hand, many people around the world believe they have a justifiable to end their life but are unable to do it for medical, mental, or religious reasons. Physician-Assisted Suicide (PAS) is a method in which a doctor provides a deadly amount of medication that kills the patient in the most humane way feasible. This method varies from others, such as euthanasia, in that the patient chooses when to take the drug and terminate his life. There are several discussions about whether assisted suicide is morally correct or not, and thus whether it should be legalized. Opponents of this medical operation, particularly those with strong religious beliefs, argue that people should never choose when to terminate their lives, regardless of their health (Oehmichen, M., & Meissner, C. 2003). Further, the majority of religions oppose euthanasia. The arguments are mainly founded on the beliefs that God gives life and that humans are created in his likeness. Thus, Creator that no one but God has the right to dispose of. As a result, we should appreciate birth and death because they are part of God's established life processes, and killing anyone, whether the terminally ill or the elderly unable to move or work, is not a legally available decision for the doctor, the patient's family, or the patient himself. As a result, no human being has the authority to take an innocent person's life, even if that person wishes to die. However, a person's life may go through difficult circumstances when he is afflicted with difficult or incurable diseases that may lead him to a state of disability or despair of recovery, with the accompanying excruciating and unbearable pain. This fact raised the issue of euthanasia, which has become one of the controversial issues in the world in terms of its legality and the attempt to justify it morally, religiously and legally (Baeke, G., Wils, J. P., &Broeckaert, B. (2011).

Euthanasia comes in the concept of religious ethics and values. So the world values survey focuses on the respondent's perception of this aspect. A study by Sultana Begum (2021) explored the variance based on gender for the economic values variable and found that there is significant variance based on gender for the economic values variable. In this paper, the researchers attempt to explore the question of whether variance based on gender, age, education and religion of the respondent make any impact on the perception of the variable justifiability on euthanasia.

2. Literature review:

The concept of physician-assisted death remains divisive, with medical societies, religious organizations, physicians, and the general public holding opposing viewpoints on its morality. However, the process of dying has undergone significant transformations, without a doubt. There were some notable success stories linked to mortality patterns by the end of the twentieth century. Also, Euthanasia has many forms and methods. The first: active or direct killing, such as giving the patient a lethal dose of a drug prepared for that, and it takes the forms: the voluntary or voluntary case based on a pre-written will from the patient, and the involuntary case when the patient is unconscious, so the doctor assesses the patient's condition. The second: assisting suicide, such as shooting in the head, or jumping from a high place. The third: indirect killing, by giving the patient drugs to calm the pain, and over time, these drugs have complications in thwarting breathing and discouraging the work of the heart muscle, and eventually death. Fourth: It is ineffective killing, which is done by refusing to treat the patient or stopping the necessary treatment such as vital devices to preserve life, or stopping the work of the machine, or reducing the amount of oxygen, or giving the patient special medications in stages that lead to stopping the work of the heart (Dr. Roger Woodruff (2019). Increased demand for physicians' involvement in life-ending decisions has sparked substantial debate among social, political, and medical groups on euthanasia and right-to-die problems. The Commonwealth Department of Health and Aged Care commissioned a study to determine if undergraduate medical students need to be educated about suicide prevention, euthanasia, and other life-ending issues (De Leo, D., Hawgood, J., & Ide, N. 2012).

Griffith University's lecturer professor, Diego De Leo in his research, he asked (373) medical students to rate their attitudes about euthanasia issues. Twenty-four general practitioners (GPs) were asked to rate the importance of a specialized suicide prevention, euthanasia, and life-ending concerns

DOI: 10.9756/INT-JECSE/V14I3.162

curriculum in six different states (rural/urban settings). Results Medical students were especially interested in learning about euthanasia and other life-ending problems (76.8%), quality of life and death (85.1%), and different types of euthanasia and physician-assisted suicide (76.8%). (70 percent). They believe that physicians should be included in end-of-life decisions (89 percent). 40% of AMS believe that education on euthanasia and other life-ending issues is required. 54 percent of GPs regarded euthanasia education and related concerns as a high priority. Chronic sickness is becoming more common, and the aging population necessitates more physician engagement in this difficult field of medicine. Around the world, the demand for undergraduate education in these fields is recognized as vital and urgent (De Leo, D., Hawgood, J., & Ide, N. 2012). Further in support of the above study, Gerald Dworkin, R. G. Frey &Sissela Bok He depicts an ideal state and advocates for regulations to be enacted to control rather than outright prohibiting individuals from assisting people who wished to die if it relieved a person who was near death and in excruciating agony. Their main motivation was to create regulations to safeguard family members who may otherwise alleviate the anguish of a love done wrong. (Dworkin, G., Frey, R. G., & Bok, S. 1998)

Furthermore, (Timothy J. LePh.D. PhD, PsyD, and Yvette Brazier 2018) demonstrate that in the case of euthanasia, a doctor is legally allowed to end a person's life painlessly provided the patient and their family approve. When a doctor assists a patient in committing suicide at their desire, this is known as assisted suicide. Furthermore, both voluntary and involuntary Euthanasia is divided into two types: elective and involuntary. When euthanasia is performed with the patient's consent. Voluntary euthanasia is currently legal in Belgium, Luxembourg, the Netherlands, Switzerland, and the US states of Oregon and Washington. Non-voluntary euthanasia is when euthanasia is administered on someone who is unable to consent owing to their present health condition. Another appropriate person decides on the patient's behalf, based on their quality of life and suffering. Involuntary euthanasia is defined as euthanasia performed on a person who would be able to provide informed permission but does not, either because they do not wish to die or because they were not asked. Because it is frequently done against the patient's will, this is referred to as murder. Both passive and active euthanasia are available. Involuntary euthanasia and voluntary euthanasia are the two forms of euthanasia techniques. Passive euthanasia occurs when life-sustaining therapies are not provided. There are certain ambiguities in the definitions. A patient may become toxic if a doctor delivers larger and higher doses of potent medications, such as opioids. Some would argue that this is euthanasia by inaction. Others claim that this is not euthanasia because no one's life is stolen. When a person, whether the patient or someone else, utilizes fatal substances or forces to end a patient's life, this is known as active euthanasia (Timothy J. Legg, PhD, PsyD, and Yvette Brazier 2018). Active euthanasia is more divisive, with religious, moral, ethical, and humanistic concerns more likely to be raised.

In addition, in his essay, Jacobs, R. K., and Hendricks, M. (2018) state that euthanasia/physician-assisted suicide has been a divisive and occasionally off-limits topic internationally. Recent research and a court case have revived the debate on the topic. In South Africa, there has yet to be a consensus on whether to accept or reject these practices. Before policy can be informed, all relevant role players must be effectively engaged. The overall response rate (N=277) was 69.3 percent. In sum, 52.7 percent of respondents (n=146) believed that euthanasia/ physician-assisted suicide (PAS) should be legalized in South Africa. The responses vary based on the patient's ailment. 41.9 percent of participants said they would end a patient's life if they had a terminal disease that caused intractable misery. Another 36.1 percent answered they would not participate in ending a patient's life, while 35.0 percent said they would be comfortable providing the patient with the appropriate means to terminate their life PAS. The majority of participants (80.1%) said they would rather have a dedicated ethics council select who gets euthanasia or PAS. Many factors influenced participants' replies, but the findings revealed significant disparities in opinion between and within religious groups. He came to the conclusion that significantly more people in this study were open to legalizing euthanasia/PAS than in earlier studies. Only 41.9 percent of responders, on the other hand, would contemplate conducting euthanasia/PAS on some patients. Before policy can be informed, other healthcare personnel and the general public must be consulted (Jacobs, R. K., & Hendricks, M. 2018).

Additionally, Euthanasia is condemned by almost all religions. Some of them outright prohibit it. The Islamic perspective on death is unmistakable. Allah is the one who controls life and death.

A Muslim is supposed to understand and accept that there are divine causes in life becoming unpleasant and in the postponement of one's chosen death. Ending one's own life or requesting someone else to do so is considered an attempt to share Allah's power, hence it is considered an unforgivable sin. The Quran forbids anybody from wishing for death and considered as a greatest sin suicide (Worthington Jr, E. L., &Sandage, S. J. (2001). This circumstance has an impact on the family and leads to social isolation. On the other hand, for example, the Roman Catholic Church is one of the most vocal opponents of euthanasia (Oguz, N. Y. 1996). Those who become vulnerable due to disease or disability deserve special care and protection, according to nearly all religions, and good end-of-life

DOI: 10.9756/INT-JECSE/V14I3.162

care is far preferable than euthanasia. Yale Kamisar's publications add up to a convincing argument against assisted suicide and euthanasia legalization, an accomplishment made all the more noteworthy because it avoids becoming involved in the contemporary moral pluralism discussion by avoiding a broad moral condemnation of these acts. his main purpose, however, was to investigate the role of religious thought in arguments over the morality of physician-assisted suicide (PAS)/euthanasia, as well as the moral consequences of its legalization.

Despite the fact that many people oppose physician-assisted suicide, it should be legalized according to the findings of the previous studies, because it relieves suffering, allows patients to die with dignity, and allows people to take control of their life's most important decision, death, away from their terminal illness, In many issues, however, religious individuals are perceived as being more fearful of assisted suicide than secular people. While some believe that euthanasia is morally justified and/or necessary to end the life of an incurably ill person or when it is preferred for the individual's suffering, others reject the legalization of physician-assisted death, which would allow the private killing of one person by another. The public's ability to regulate and manage such activities would be extremely difficult, if not impossible. Religious beliefs, on the other hand, are more specific in emphasizing that, while we are not bound to avoid death at all costs, we should not purposefully intervene to bring death about. Because the "sanctity of life" concept is based on the human person's unique relationship with God, human life is a basic value. Under this theory, it would be illegal to take direct action to end the life of a terminally ill patient. However, the sections below, in which the data are evaluated, demonstrate this more clearly from the various perceptions. A study conducted by Sultana Begum(2021) on world values survey on the Economic values variable proved a significant variance among the male and female respondents. Another study by (Aziza Kavulu, Sultana Begum, 2021) focused on ethics and values and explored the Justifiability of three variables related to violence against others. This study explores the justifiability of Euthanasia by the respondents of worth values survey (WVS,2020)

3. Methodology:

The paper used the primary data collected through the seventh wave of the World Values Survey (WVS) which is conducted around the world from 2017 to 2020. In this paper, the data collected from all 51 countries are used. The total respondents are (N=76846) among which 36,556 are male and 40,290 are female respondents. A study conducted by (Aziza Kavulu, Sultana Begum, 2021) using Worlthed values survey for the variables Justifiability of violence states that there is statistically significant variance based on gender, education and age groups. The researchers found a research gap where the variable Justifiability for the Euthanasia is not studied and hence this initiative. As this is a representative sample taken by the team of WVS the data is reliable and can be used for generalizing the findings.As mentioned in the analysis part, the data found to be slightly skewed towards and normality test shows that the data is not normally distributed, Non parametric test like Mann-Whitney U Test[3] is run to explore the variance between males and females, and the Kruskal Vallis test[4] is run to look at the variance based on Education level, age and Religion of the respondents. Mean values are taken to investigate in-depth differences. The data passes through the assumption of the Mann-Whitney U Test and Kruskal Wallis as the dependent variable is ordinal or continuous, that is 'Never justifiable at all' to 'always justifiable' with a scale of one to ten, (1 being,Never justifiable and 10 being Always justifiable). The independent variable gender is a categorical independent group of male and female as well as distinct respondents for education, age and religion groups.

Hypothesis:

Null Hypothesis:

$H^0$1: There is no significant variance in the perspectives on the Justification of Euthanasia based on the factors like Gender, Age, Education and Religion

Research Hypothesis:

$H^1$1: There is significant variance in the perspectives on the Justification of Euthanasia based on the factors like Gender, Age, Education and Religion.

4. Analysis:

The following paragraphs confer the data analysis.

Table 1: Descriptive Statistics of the Variables:

Descriptive Statistics

[3]https://statistics.laerd.com/spss-tutorials/mann-whitney-u-test-using-spss-statistics.php

[4]https://statistics.laerd.com/spss-tutorials/kruskal-wallis-h-test-using-spss-statistics.php

DOI: 10.9756/INT-JECSE/V14I3.162

		Justifiable: Euthanasia	Gender	Age of the Respondent	Education	Religion
N	Valid	73873	76846	76579	76278	5833
	Missing	3024	51	318	619	1064
Mean		3.77	1.52	3.3202	2.00	3.04
Median		2.00	2.00	3.0000	2.00	3.00
Mode		1	2	2.00	2	5
Std. Deviation		3.135	0.499	1.58986	0.804	2.648
Skewness		0.732	-0.097	0.183	0.000	0.440
Std. Error of Skewness		0.009	0.009	0.009	0.009	0.009
Kurtosis		-0.875	-1.991	-1.086	-1.454	-0.981
Std. Error of Kurtosis		0.018	0.018	0.018	0.018	0.018
Minimum		1	1	1.00	1	0
Maximum		10	2	6.00	3	9

Source: Own computation data taken from WVS

Table 1 depicts the descriptive statistics of the variables taken for this study. The total respondents for this variable taken for this study is 73873(N) with minimum taken as 1 which is Never justifiable euthanasia to maximum 10 which is Always justifiable euthanasia. The standard deviation is near to the mean values and the values for asymmetry and kurtosis are between -2 and +2 are considered acceptable in order to prove normal univariate distribution (George & Mallery, 2010). Hair et al. (2010) and Byrne (2010) argued that data is considered to be normal if skewness is between -2 to +2 and kurtosis is between -7 to +7.However the normality test (Kolmogorov-Smirnov) shows the data is not normally distributed for the dependent variable with significance value of (0.00) which is less than (0.05) Since the data falls outside the normal distribution the researchers have done the rest of the analysis based on assumptionthat the data is not normally distributed and hence used Non-Parametric tests instead of parametric tests.

Table 2: Gender

Gender					
		Frequency	Per cent	Valid Percent	Cumulative Percent
Valid	Male	36556	47.5	47.6	47.6
	Female	40290	52.4	52.4	100
	Total	76846	99.9	100	
Missing	Other missing; Multiple answers Mail (EVS)	34	0		
	No answer	17	0		
	Total	51	0.1		
Total		76897	100		

Source: Own computation data taken from WVS

Table 2 depicts the Gender frequency and per cent. There are 47.6% males and 52.4% females who participated from 51 countries in the world values survey.

Table 3: Descriptive statistics of the Variable taken for taken for this study: Euthanasia

Justifiable: Euthanasia					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never justifiable	31963	41.6	43.3	43.3

DOI: 10.9756/INT-JECSE/V14I3.162

	2	5676	7.4	7.7	51
	3	4112	5.3	5.6	56.5
	4	3193	4.2	4.3	60.8
	5	8125	10.6	11	71.8
	6	4027	5.2	5.5	77.3
	7	3650	4.7	4.9	82.2
	8	4396	5.7	6	88.2
	9	2412	3.1	3.3	91.4
	Always justifiable	6319	8.2	8.6	100
	Total	73873	96.1	100	
Missing	**Other missing; Multiple answers Mail (EVS)**	53	0.1		
	No answer	590	0.8		
	Don´t know	2381	3.1		
	Total	3024	3.9		
Total		76897	100		

Source: Own computation data taken from WVS

Table 3 depicts the number of participants responded for each option of the response. It can be observed that more number of participants, almost 41.6% of the respondents responded as Never Justifiable Euthanasia. Only 8.3% responded as always justifiable. This shows most of the respondents are against this concept of euthanasia.

Table 4:

Age					
		Frequency	**Percent**	**Valid Percent**	**Cumulative Percent**
Valid	**16-24**	11112	14.5	14.5	14.5
	25-34	16458	21.4	21.5	36
	35-44	15298	19.9	20	56
	45-54	13376	17.4	17.5	73.4
	55-64	11176	14.5	14.6	88
	65 and more years	9159	11.9	12	100
	Total	76579	99.6	100	
Missing	**System**	318	0.4		
Total		76897	100		

Source: Own computation data taken from WVS

Table 4 depicts the range of age of the participants. 14.5% of respondents are in of the age group of 16-24 years of age. 21% of respondents are of the age group of 25-34 years of age and so on. There are around 11.90 % of respondents who are in the age group of 65 years and above.

Table 5:

Age- Mean
Age and Justifiability cross tabulation

DOI: 10.9756/INT-JECSE/V14I3.162

Justifiable: Euthanasia			
Age of the Respondent	Mean	N	Std. Deviation
16-24	3.58	10681	3.025
25-34	3.66	15836	3.061
35-44	3.66	14711	3.097
45-54	3.77	12899	3.117
55-64	3.91	10697	3.21
65 and more years	4.2	8754	3.339
Total	3.77	73578	3.135

Source: Own computation data taken from WVS

The Table 5 depicts the age and Justifiability of euthanasia cross tabulation. It can be observed that the there is a direct relationship between the age if respondent and the mean values. The respondent in the age group of 16-24 have the mean value of 3.58 and it is increasing for every set of age group and the highest mean is 4.2 for the age group of 65 and more years.

Table 6: Mean of Education of the Respondents:

Justifiable: Euthanasia * Education of the Respondent			
Justifiable: Euthanasia			
Education of the Respondent	**Mean**	**N**	**Std. Deviation**
Lower	2.94	23641	2.83
Middle	3.83	25938	3.152
Higher	4.53	23767	3.201
Total	3.77	73346	3.135

Source: Own computation data taken from WVS

Table 6 depicts the mean of education of the respondents. It can be observed that lower educated respondents less justify it and higher educated respondents justify euthanasia more. This is further investigated for statistically significant variance in the later part of the paper.

Table 7 Religion of the Respondents:

Justifiable: Euthanasia * Religion				
Justifiable: Euthanasia				
Religion	**Mean**	**N**	**Frequency**	**Per cent**
Do not belong to a denomination	5.44	17086	17548	22.8
Roman Catholic	3.87	13835	14530	18.9
Protestant	3.80	5106	5321	6.9
Orthodox (Russian/Greek/etc.)	3.27	6081	6623	8.6
Jew	5.46	213	213	0.3

DOI: 10.9756/INT-JECSE/V14I3.162

Muslim	2.33	20717	21381	27.8
Hindu	3.47	527	536	0.7
Buddhist	3.72	4878	4934	6.4
Other Christian (Pentecostal/Free church/Jehovah...)	3.92	2619	2722	3.5
Other	4.73	1933	2025	2.6
Missing				1.4
Total	3.76	72995	75833	100

Source: Own computation data taken from WVS

The Table 7 above depicts the mean values of Religion and Justification of Euthanasia cross tabulation. It can be observed that Muslim participants have responded more for, never justify the concept of Euthanasia and have the lowest mean whereas highest mean is observed among the Jews and those who do not belong to any religion or atheist with the value of 5.46 and 5.44 respectively.

Table 8: Hypothesis Test Summary:

Hypothesis Test Summary				
S. No.	**Null Hypothesis**	**Test**	**Sig.**	**Decision**
1	The distribution of Justifiable: Euthanasia is the same across categories of Gender	Independent Samples Mann Whitney U Test	0.107	Retain the null hypothesis
2	The distribution of Justifiable: Euthanasia is the same across categories of Age	Independent Samples Kruskal - Wallis Test	0.000	Reject the null hypothesis
3	The distribution of Justifiable: Euthanasia is the same across categories of Education	Independent Samples Kruskal - Wallis Test	0.000	Reject the null hypothesis
4	The distribution of Justifiable: Euthanasia is the same across categories of Religion	Independent Samples Kruskal - Wallis Test	0.000	Reject the null hypothesis
Asymptotic significances are displayed.			**The significance level is .05**	

Source: Own Computation data from WVS

The Table 8 illustrates the hypothesis tests run to find the variance based on the factors Gender, Age, Education and Religion. Except Gender (0.107) for all the other factors it is found that the significance is below (0.05). Hence it is proved that that there is significant variance among the respondents in the factors of age, education and religion for the Justification of Euthanasia.

6. Findings:

1. A lower mean value means lesser justification for euthanasia. A higher value of mean indicates greater justification.
2. Among the 73,873 respondents from around fifty one countries, 31,963 (41.6 %) responded as never justifiable euthanasia.
3. All the 51 countries mean value is 3.77 which is higher than the mean of some religions like, Muslims, Hindus and orthodox respondents.
4. The difference in mean of male and female is not statistically significant.
5. Muslims religion has the lowest mean and this means they never justify Euthanasia.

DOI: 10.9756/INT-JECSE/V14I3.162

6. The respondents with the Age group of 65 and above the mean value is more. This means that the person when get older they are justifying euthanasia than the younger age respondents.
7. There is no significant variance among various categories of gender for the justification of euthanasia. This means men and women perceive euthanasia in a similar manner.
8. There is significant variance among various categories of age groups in the perception of justification of euthanasia. There is also direct relationship, older the age higher they justify.
9. There is significant variance among various categories of Education.
10. Higher education respondent's mean value is more than the lower educated respondents. This means higher educated respondents justify euthanasia.
11. There is significant variance among different categories of religion on the justification of euthanasia.

8. Conclusions:

These findings may contribute to the societal and ethical discussion over euthanasia, which has traditionally been framed primarily from a medical standpoint. Ethical thought from a variety of perspectives can help to both inform and challenge the formulation of clinical practice recommendations and regulations linked to euthanasia. The viewpoint broadens the euthanasia debate by offering much-needed critical insights into palliative care education, communication skills, emotional positioning, decision-making, and ethical principles. This can help not just health care professionals, families, and patients who are directly involved in the euthanasia process, but also all members of a society in their critical thinking on the topic and why more empirical research, as well as ethical thinking, is necessary and must not be abandoned on this subject. Euthanasia justification is same across the categories of men and women but not the same among the categories of age, education and religion. The study contributed some empirical evidence on the beliefs based on gender and religion.

9. Limitations:

The study took the data available (51 Countries only) from the seventh wave of World Values Survey. Country wise analysis will be more informative. Hence generalization cannot be done for the other countries data which are not available.

10. Future Research:

The researchers plan to study and analyze the variances country specific and region specific, so that generalizations can be done.

11. Acknowledgments:

The results of the analysis for this research paper are derived from the recorded variables from the world values survey's seventh wave data. Therefore, all the credits and all the value aspects go to the World Values Survey Team for providing the data source and we acknowledge our special thanks to the Tishk International University Management for providing a congenial environment and encouragement to conduct this research.

References:

Aziza Kavulu, Sultana Begum. (2021, December). An empirical analysis of Ethical Values and Norms - variances based on Education and Gender on Justification of Violence. *International Journal of Social Sciences and Educational Studies*, 298-310. doi:https://ijsses.tiu.edu.iq/index.php/volume-8-issue-4-article-20/

Baeke, G., Wils, J. P., &Broeckaert, B. (2011). 'There is a time to be born and a time to die'(Ecclesiastes 3: 2a): Jewish perspectives on euthanasia. Journal of religion and health, pp 50(4),

Byrne, B. M. (2010). Structural equation modeling with AMOS: Basic concepts, Applications and programming, New York: Rutledge

D. Birnbacher, in International Encyclopedia of the Social & Behavioral Sciences 2001

De Leo, D., Hawgood, J., & Ide, N. (2012). Do we need education on right-to-die issues? Medical perspectives from A ustralia. Asia-Pacific Psychiatry.p 1

De Leo, D., Hawgood, J., & Ide, N. (2012). Do we need education on right-to-die issues? Medical perspectives from A ustralia. Asia-Pacific Psychiatry.pp 4(-10

George, D. & Mallery, M. (2010). SPSS for Windows Step by Step: A Simple Guide and Reference, 17.0 update (10a ed.) Boston: Pearson.

Haerpfer, C., Inglehart, R., Moreno, A., Welzel, C., Kizilova, K., Diez-Medrano J., M. Lagos, P. Norris, E. Ponarin & B. Puranen et al. (eds.). 2020. World Values Survey: Round Seven - Country-Pooled Datafile. Madrid, Spain & Vienna, Austria: JD Systems Institute & WVSA Secretariat. doi.org/10.14281/18241.13

Hair, J., Black, W. C., Babin, B. J. & Anderson, R. E. (2010) Multivariate data analysis (7th ed.). Upper Saddle River, New Jersey: Pearson Educational International.

Roger Woodruff (2019) 'Euthanasia and Physician Assisted Suicide are they clinically necessary or desirable' < https://hospicecare.com/policy-and-ethics/ethical-issues/essays-and-articles-on-ethics-in-palliative-care/euthanasia-and-physician-assisted-suicide-are-they-clinically-necessary-or-desirable/> accessed on 18/1/2022

Dworkin, G., Frey, R. G., & Bok, S. (1998). Euthanasia and physician-assisted suicide. Cambridge University Press.

Hiscox, W. E. (2002). Euthanasia, Death with Dignity and the Law. By Hazel Biggs.[Oxford: Hart Publishing. 2001. xvi, 174 and (Index) 5 pp. Hardback£ 25.00 net. ISBN 1–84113–091–5.]. The Cambridge Law Journal, 61(2)

Jacobs, R. K., & Hendricks, M. (2018). Medical students' perspectives on euthanasia and physician-assisted suicide and their views on legalising these practices in South Africa. South African Medical Journal, 108(6), 484-489.

Lewy G. Assisted suicide in US and Europe. New York: Oxford University Press, Inc; 2011.

Oehmichen, M., & Meissner, C. (2003). Active euthanasia and physician-assisted suicide: the German discussion. Legal Medicine, 5, u

Oguz, N. Y. (1996). Euthanasia in Turkey: cultural and religious perspectives. Eubios Journal of Asian and International Bioethics.pp1-2.

Sultana Begum, Waqar Ahmed (2021)"Economic Values and Gender Variance An Empirical Analysis" Turkish Online Journal of Qualitative Inquiry (TOJQI) July 2021: 4224, Volume 12, (Issue 8), 4224-4233.

Timothy J. Legg, PhD, PsyD, and Yvette Brazier (2018) 'What are euthanasia and assisted suicide?' <https://www.medicalnewstoday.com/articles/182951> accessed on 18/1/2022

Unnamed (1976) 'Euthanasia and a Proper Death'< https://www.123helpme.com/essay/Euthanasia-Essay-A-Proper-Death-19765 accessed on 17/1/2022

Worthington Jr, E. L., &Sandage, S. J. (2001). Religion and spirituality Psychotherapy: Theory, research, practice, training.pg.38(4)

DOI: 10.9756/INT-JECSE/V14I3.162