# EUTHANASIA DECISIONS:

# INFLUENCE OF METHOD EMPLOYED, PERSON INVOLVED

# AND SITUATIONAL CONSIDERATIONS

by

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Euthanasia decisions: Influence of method employed, person involved and situational considerations

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Abstract

Eight hundred and ten respondents from the Greater Vancouver area completed a mailed survey concerning attitudes toward euthanasia. Respondents read one of four scenarios, where method of euthanasia (e.g., lethal injection versus life-support withdrawal) was crossed with person dying (e.g., self imagined as terminally ill versus other). Respondents rated the acceptability of the request for euthanasia presented in the scenario they read, as well as the importance of 14 situational components in arriving at their decision of whether to support euthanasia (e.g., severity of physical pain, psychological distress, cost of treatment, etc.). Life-support withdrawal was judged as being significantly more acceptable than a lethal injection, but the person involved did not affect the acceptability of euthanasia. The situational components were rank ordered differently in each scenario, and nine of them were rated as being significantly more important when making decisions about self compared to other. Factor analyses performed on the importance ratings of the situational components revealed a two-factor structure for "other" scenarios, and a three-factor structure for "self" scenario. These results suggest that respondents use greater scrutiny and consider the decision more complex when deciding about themselves than about others. Situational components explained 36% of the variance in acceptability of euthanasia, while respondents' degree of religious commitment, which was inversely related to the acceptability of euthanasia, explained 16% of it. The findings reflect the idiosyncratic nature of euthanasia decisions and are discussed in the context of the establishment of possible guidelines for the regulation of euthanasia.

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## Introduction

Euthanasia certainly is not a recent concept, but the paradoxical stand of modern medicine, torn between an ever increasing capacity to prolong life and an inability to cure a number of debilitating diseases, has given the ending of life an entirely new meaning. The euthanasia debate can no longer be kept under cover with the news publicizing increasing instances of people resorting to the services of "Death Doctors" (e.g., Dr. Quill, Dr. Kevorkian), seeking court approval to be permitted a physician-assisted suicide (Rodriguez v. British Columbia, 1993), or campaigning for the right to die with dignity (e.g., Americans Against Human Suffering). Recent polls suggest that 77% of Canadians (Toronto Star, 1992, November 23, p.A1,A7) and 60% of physicians (Montreal Gazette, 1993, August 25, p.B1) support euthanasia, that 90% of the Canadian public support the right to die naturally (Toronto Star, 1983, May 27, p.A3), and that a vast majority of Quebecers favor active euthanasia (Medical Post, 1990, November 13, p.6).

Debates about the acceptability of euthanasia often revolve around key arguments such as the right to autonomy and privacy, the method involved (e.g., active versus passive euthanasia), the quality of life of terminally ill patients and the process involved in making decisions about life and death. These key issues will be reviewed briefly below.

### The Right to Autonomy and Privacy

Central to the euthanasia debate are fundamental human rights such the right to autonomy and the right to privacy, two cornerstones of medical ethics. Autonomy

recognizes people's capacity to understand and make their own decisions, the uniqueness of their phenomenology, and their legitimate access to accurate information (Klagsbrun, 1991; Latimer, 1991). Privacy entails protection against undesired, invasive treatment (Wanzer et al., 1989). A patient's desire, however, even when clearly expressed, does not render euthanasia ethical or acceptable (Brescia, 1991; O'Rourke, 1991). When the wish to die is expressed, questions arise as to whether this request stems from either depression or disease symptoms that are treatable (Cassem, 1979; Jackson & Youngner, 1979; Klagsbrun, 1991; Rabkin, Gillerman, & Rice, 1976; Wanzer et al., 1989), from an attempt to mask other, less socially acceptable problems, or from a fear of treatment based on misperception or misinformation (Jackson & Youngner, 1979; Wanzer et al., 1989). Many agree that physicians ought to investigate such motives before deciding what action to take (Cassem, 1979; Rabkin et al., 1976).

In recognition of the patient's rights to autonomy and privacy, both the Canadian Law Reform Commission and the U.S. Presidential Commission recommend that competent patients be given the right to refuse life-sustaining treatment (see Winkler, 1985). Many states have enacted laws providing for Living Wills by means of which patients refuse the resort to heroic measures for their care in the event of terminal illness, as well as laws protecting physicians complying to these wills against possible action by the patient's family (Jackson & Youngner, 1979; Wanzer et al., 1989; Zucker, 1977). However, even though these documents would help clarify patients' wishes, particularly when their condition does not allow communication, Living Wills

are rarely discussed and signed in standard medical practice (Annas, 1990; Wanzer et al., 1989).

Personal autonomy has its limits: Whereas most health care professionals feel that living wills should be legally acceptable, only a slight majority agree that they should be legally binding and should adhere in all situations (Bosmann, Kay, & Conter, 1987). Furthermore, according to the principle of fundamental justice, personal autonomy sometimes has to be restricted in the context of the greater good of society (Latimer, 1991; Pellegrino, 1989). Many fear that the legalization of active euthansasia would become a "slippery slope", resulting in possible misuse against vulnerable members of our society, particularly the diseased, the elderly, and those perceived as emotional and economical burdens for society (Chipeur & Maxwell, 1994; Hollander, 1989; Pellegrino, 1989; Rodriguez v. British Columbia, 1993; Yarnell & Battin, 1988). The so-called "right to die" might quickly turn into a "duty to die" (Van Der Sluis, 1988, p.108).

Active versus Passive Euthanasia

Beyond the discourse about the boundaries of autonomy and privacy, another great source of controversy pertains to the means involved in ending life. One distinction that often is referred to is passive versus active euthanasia. Active euthanasia generally is perceived as a commission, engaging in an action that directly causes death, usually within a few hours (O'Rourke, 1991; Winkler, 1985). By contrast, passive euthanasia is perceived as an omission, where death is allowed to occur by letting the disease run its course (O'Rourke, 1991; Winkler, 1985). Some push the

distinction further, separating physician-assisted suicide from active euthanasia, the former involving performance of the final act by the patient, the latter requiring more direct action by the physician (Wanzer et al., 1989).

It is generally agreed that "killing" a patient is worse than "doing nothing" to prevent a patient from dying (Rachels, 1975; Winkler, 1985). A survey of health care professionals found that 87% approved of passive euthanasia, defined as "employing no extraordinary means to prolong the patient's life" (Bosmann et al., 1978, p.1), whereas only 21% supported active euthanasia, defined as "a direct action taken to shorten or terminate the patient life" (Bosmann et al., 1987, p.1). This survey also concluded that instances of passive euthanasia occurred more frequently and were reported more often (Bosmann et al., 1987). The American, British, Canadian and World Medical Associations state that the deliberate ending of a life is unethical, regardless of the patient's request, yet that it is permissible to honor a terminally ill patient's request to let the disease follow its course (see Williams, 1991; Rodriguez v. British Columbia, 1993). Health-care providers who withdraw life-sustaining devices and issue "do not resuscitate" orders are no longer condemmed by either civil or criminal courts, whereas those who decide to participate in physician-assisted suicide face criminal and civil liability (Latimer, 1991; Lynn, 1988; Rachels, 1975; Wanzer et al., 1989). Nevertheless, instances of physician-assited suicides, even though seldom reported, are believed not to be rare (Wanzer et al., 1989).

Many argue that the distinction between active and passive euthanasia is morally irrelevant (Lynn, 1988; O'Rourke, 1989; Rachels, 1975; Winkler, 1985). The Vatican

considers both to go against the moral obligation of maintaining life, and condems those who ask for, recommend or permit it (see O'Rourke, 1989). Others argue that, because the intrinsic goal of both is the elimination of human suffering, they are no different (O'Rourke, 1991; Winkler, 1985). Furthermore, once the decision has been made not to prolong agony, some circumstances may even justify considering active rather than passive euthanasia (Rachels, 1975).

The line between passive and active euthanasia may be hard to draw (Lynn, 1988; Winkler, 1985). In some circumstances, one may kill by refraining from some action (e.g., killing by starvation), and in others, one may allow death to occur by doing something (e.g., issuing DNR orders) (Winkler, 1985). Aggressive treatment of the terminally ill, which may involve administration of lethal doses of sedatives, entraining respiratory depression and precipitating death, is not seen as killing because the primary intent is to provide pain relief (Klagsbrun, 1991; Latimer, 1991; Lynn, 1988; O'Rourke, 1991; Rachels, 1975; Roscam-Abbing, 1988). However, such aggressive treatment may not only "kill" but also violate the right to privacy if performed without specific considerations of the patient's wish and needs (Latimer, 1991). The intentionality involved in these actions poses a problem (Winkler, 1985).

There is considerable controversy over what can be considered treatment as opposed to basic supportive care (Bosmann et al., 1987; Latimer, 1991). This is relevant particularly in cases involving cessation or noninitiation of artificial feeding and hydration for infants as well as for elders. However, many physicians and courts now agree that there are no differences between feeding and hydrating techniques and

other life-sustaining devices (Annas, 1990; Lo, 1984; Nevins, 1986; Wanzer et al., 1989).

Quality of Life and Decision-Making

Another important issue involved in treatment decisions is the quality and the meaningfulness of the life that is maintained, because a longer life may not always be a happier life (Rachels, 1975; Winkler, 1985). As emphasized by both the Canadian Law Reform Commission and the U.S. Presidential Commission reports, in the case of incompetent patients treatment should not be undertaken if it results in pain and in a quality of life rated as "medically unacceptable" (in Winkler, 1985). However, no where is the concept of medical acceptability defined and few agree on the meaning of quality of life (Van der Meer, 1988; Whitehead, 1994; Winkler, 1985). The only condition which is considered by most to result in a poor quality of life is brain death, the only truly irreversible condition of which we know (Black, 1978; Imbus & Zawacki, 1978; Lo, 1984).

Health care professionals generally believe that the establishment of clear guidelines regarding euthanasia would facilitate decisions about whether or not life shoud be prolonged or ended, especially in cases involving incompetent patients (Bosmann et al., 1987; Cassel & Meier, 1990; Yarnell & Battin, 1988). Such guidelines exist in the Netherlands, where euthanasia is still illegal but is sanctioned by the state in a number of cases meeting specific criteria (see Wanzer et al., 1989; see Angell, 1988, for a review of the Royal Dutch Medical Association Report, 1986). These criteria include: (1) that the patient's request be voluntary, stable and enduring;

(2) that the patient be undergoing suffering that is the patient's view intolerable; (3) that all alternatives acceptable to the patient for relieving the suffering have been tried; (4) that the patient be competent and has full information; and (5) that the physician has consulted with a second physician whose judgement can be expected to be independent.

Along these guidelines exists an expectation that physician who become involed in instances of active euthanasia or assisted suicide report to the judicial authorities. In 1991, physicians performed active euthanasia by administering drugs in 2300 cases, and participated in physician-assisted suicide by prescribing and providing drugs in 400 cases (Van Der Maas, Van Delden, Pijnenborg & Looman, 1991). Of those cases, 454 were investigated by the public prosecutor and were all dismissed (Van der Maas et al., 1991). However, it is believed that reported cases represent a small fraction of actual instances of euthanasia: current estimates of the frequency of euthanasia range between 3000 and 8000 a year, or 5 to 15% of all deaths (Angell, 1988; Borst-Eilers, 1991, in Battin, 1991; Huyse & Van Tilburg, 1993).

In the United States, propositions for the legalization of euthanasia were placed on the election ballots in 1991 in the state of Washington, in 1992 in California, and in 1994 in Oregon. The guidelines proposed in Washington were more stringent than those in place in the Netherlands, requiring a candidate for euthanasia to have a life expectancy of less than six months, as certified by two physicians, and requiring two disinterested witnesses to certify that the patient's request was voluntary. In California, the proposed legislation introduced even stricter safeguards, yet permitted

euthanasia by advance directive. The successful approval of the Oregon proposal suggest that adequate safeguards might be the key to success, and that physician-assisted suicide, which involves a greater involvement on the part of the patient, may be perceived as more acceptable than active euthanasia. Amongst the guidelines proposed in Oregon, three pivotal ones include: (1) the patient has to have a life expectancy of less than six months; (2) the patient has to request a lethal dose on three occasions; and (3) the patient has to inject the dose him/herself ("The 1994 Elections", 1994).

Some believe that attempts at proposing changes in euthanasia legislations prior to 1988 failed because of lack of organization, rather than voter sentiment, or because of concerns over possible abuse (Angell, 1988), and others suggest that future attempts may succeed as support for euthanasia, as monitored by public opinion polls, increases (Yarnell & Battin, 1988).

Public Opinion and Previous Research

A number of attempts have been made to identify the basic topography of public opinion toward euthanasia. Among the most influential variables is religiosity, or attendance at religious services (Adams, Bueche, & Schvaneveldt, 1978; Anderson & Caddell, 1993; Jorgensen & Neubecker, 1980; Ostheimer & Moore, 1981; Shuman, Fournet, Zelhart, Roland, & Estes, 1992; Singh, 1979; Wade & Anglin, 1987). Singh (1979), by means of a regression analysis using National Opinion Research Center data, examined opinions of some 1530 individuals and found a strong influence of religiosity, as measured by religious service attendance and self-reported strength of

religion. Religious participation was also the best predictor of both euthanasia ideology and behavior in a survey of college students across the United States, with lower levels of religious participation correlating with greater pro-euthanasia attitudes (Adams et al., 1978). Wade and Anglin (1987), in a study of how people think of euthanasia for themselves and for their parents, found that low levels of religiosity correlated with greater acceptance of euthanasia, when subjects were dichotomized according to a median-split into high and low religiosity groups. In a survey of registered nurses, euthanasia ideology was found to be best predicted by strenght of religious beliefs and professional experience, whereas euthanasia behavior was best related to personal values (Shuman et al., 1992). Anti-euthanasia attitudes were strongly influenced by increased religious beliefs, whereas liberal political views predicted a pro-euthanasia stance (Shuman et al., 1992). Ho and Penney (1991) failed to find a significant relationship between religiosity and euthanasia attitudes. However, their failure to find this last relationship may be due to having measured religiosity as a continuous variable in a small sample (Ho & Penney, 1991), as opposed to other studies with few subjects in which it was dichotomized (Wade & Anglin, 1987).

The role of religious affiliation per se is less clear cut. Singh (1979), who used national survey data, failed to identify religion, dichotomized into Catholic versus non-Catholic, as a significant predictor of euthanasia attitudes. However, reanalyses of the same data by Ostheimer and Moore (1981), using religion as a dummy variable rather than as a falsely dichotomized one, did reveal a significant difference between

Protestant belief and that of Jews and non-religious. However, Wade and Anglin (1987) failed to replicate such findings in a sample of university students.

Other demographic variables inconsistently found to influence euthanasia attitudes were age and education. Age was found to be directly correlated with pro-euthanasia attitudes by some (Adams et al., 1978; Devins, 1980; Slezak, 1982), and inversely correlated by others (Haug, 1978; Klopfer & Price, 1978). A higher level of education was found by Pollard (1994) to be the best demographic predictor of acceptance of euthanasia, but was found to be only weakly correlated with euthanasia acceptability by Ho and Penney (1991).

Gender often was found to have no effect on readiness to accept euthanasia (Devins, 1980; Ho & Penney, 1991; Pollard, 1994; Slezak, 1982; Wade & Anglin, 1987), and to have only a small effect on general pro-euthanasia attitude, with males being generally more in favor (Jorgenson & Neubecker, 1981). This last relation was tentatively explained by the authors as the result of socialization, which teaches men to take action under, and women to tolerate, undesirable circumstances, which they claim might also explains higher suicide rates in males (Jorgenson & Neubecker, 1981).

In an effort to move beyond such demographic differences, Sugarman (1986) looked at attribution of physicians' behavior by students to whom he presented a series of vignettes describing various degrees of clarity in euthanasia request, as well as degree of involvement and temporal commitment to life termination on the part of the physician. He found students attributed greater responsibility to the physician and

perceived the physician's action as more morally negative and less in line with medical standards when it involved active (e.g., lethal injection) as opposed to passive means (e.g., DNR order or respirator withdrawal), or if passive means were decided upon immediately before death (e.g., withdrawal of respirator) as opposed to well in advance (e.g., DNR order) (Sugarman, 1982). However, degree of responsibility and moral evaluation were not influenced by how clear the request for euthanasia was made, with only actions made to a specific request for euthanasia being perceived as more in tune with medical standards (Sugarman, 1982).

Wade and Anglin (1987) investigated specific situations in which students would endorse euthanasia for themselves and for their parents in the absence of implicit assumptions about the inevitability of death. Even though they claim that different factors were taken into account when deciding upon euthanasia for parents than for self, close examination of the four factors that emerged from the factor analysis in each case reveals great similarities (Wade & Anglin, 1987). In both cases, physical condition, mental alertness and financial hardship/emotional stress emerged as predictive of the acceptability of euthanasia; for self, the fourth factor was lowered expectation of recovery, which for parents was combined with financial hardship, and for parents, the fourth factor was external sanction, which was included with financial hardship for self (Wade & Anglin, 1987).

Most research on euthanasia has thus far focused primarily on the demographic determinants of attitudes toward euthanasia (Adams et al., 1978; Jorgensen & Neubecker, 1980; Ostheimer & Moore, 1981; Shuman et al., 1992; Singh, 1979) and

many have looked at mass public survey data measuring global pro- and anti-euthanasia sentiments (Jorgenson & Neubecker, 1980; Ostheimer & Moore, 1980; Singh, 1979). Although variables such as religious commitment (Adams et al., 1978; Jorgensen & Neubecker, 1980; Ostheimer & Moore, 1981; Shuman et al., 1992; Singh, 1979), age (Adams et al., 1978; Devins, 1980; Slezak, 1982) and level of education (Pollard, 1994; Slezak, 1982) have been found to influence attitudes toward euthanasia, they do not explain all the variance in opinion. Few studies explicitly compared acceptance of passive versus active euthanasia (Adams et al., 1978; Bosmann et al., 1987; Ho & Penney, 1991; Jorgenson & Neubecker, 1980; Shuman et al., 1992), and many failed to provide a clear definition of both (Devins, 1980; Klopfer & Price, 1978; Sawyer, 1982; Singh, 1979; Wade & Anglin, 1987). Some researchers used vignettes in order to explore systematically the weight respondents put on various elements of a situation before making a euthanasia decision (Finkel, Hurabiell, & Hughes, 1993; Sugarman, 1986), but the use of vignettes limits the number of elements that can be investigated simultaneously and results generated so far do not permit reliable predictions of euthanasia opinions based on the elements of a situation. One study looked at individual factors that would justify requesting euthanasia for self or for a parent, but the limitations of the study include the small number of subjects, the lack of distinction between passive and active, and voluntary and nonvoluntary, euthanasia, the inclusion of conditions in which death was not implicitly imminent, and the inability to clarify the relative importance of each factor in making a decision with regards to euthanasia.

## Present Study

The present study was designed primarily to investigate how decisions about the acceptability of euthanasia are influenced by the method of euthanasia employed (e.g., a lethal injection versus the withdrawal of life-support) and the person involved (e.g., self versus other). The second goal of this research was to further our understanding of public attitudes toward euthanasia by identifying the situational components that people take into consideration when deciding whether or not euthanasia is a legitimate option in a given case. The term "situational component" is defined, for the purpose of this study, as any element of a situation, internal or external to the patient, which may be weighed by a person asked to make a decision as to whether euthanasia is a legitimate option. The goal was to investigate whether people weight the various elements of a situation involving a patient requesting either treatment withdrawal or a lethal injection in a systematic fashion before making a decision.

Unlike previous research, the current study involved: (1) a large scale public survey, which investigated, but was not limited to, some demographic determinants of euthanasia attitudes; (2) a direct comparison of the acceptability of active and passive euthanasia (defined as "the ending of life by means of a lethal injection" and as "the withdrawal of treatment which will let the disease run its course" respectively[1]); (3) an investigation of whether euthanasia decisions differ depending on whether respondents make a decision about themselves or others; and (4) an attempt at clarifying the relative importance of a number of situational components in making decisions about euthanasia.

To identify the range of situational factors that people mention when debating upon the acceptability of euthanasia, some pilot work was conducted which included an extensive literature review and a series of interviews. The main study was a mail survey.

It was hypothesized that: (1) religious commitment would be inversely related to the acceptability of euthanasia and would be the best demographic predictor of euthanasia opinions; other variables were included for exploratory purposes; and that (2) passive euthanasia would be judged more acceptable than active euthanasia. Furthermore, even though no specific predictions were formulated, it was expected that: (3) the decision-making process would differ for self and others; and that (4) some factors would systematically emerge as more important than others when making a decision about euthanasia and that most situational criteria would cluster into meaningful groups, but that this clustering might differ across the four conditions.

## Pilot Study

### Method

Participants. Twenty seven females and 13 males participated in the pilot study. Thirty-two of the participants were recruited through an introductory psychology course and earned course credits for their participation. The remaining seven were recruited among university staff who volunteered some time during their daily breaks. Demographic characteristics of the sample are summarized in Table 1.

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Insert Table 1 about here.

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Material. A copy of the instructions given to participants, as well as of the semi-structured interview used, can be found in Appendix A. For the purpose of the interview, active euthanasia was defined as "the ending of life before natural death occurs, such as by a lethal injection, which usually causes death to occur within a few hours"; passive euthanasia was defined as "not prolonging life medically, such as by withdrawing life-support, which allows the illness to run its course and death to occur at some unknown point in time".

Procedure. At the outset of the interview, participants were asked to sign a consent form and were given a feedback form. The interview included questions about euthanasia and other related concepts, such as human dignity and autonomy (see Appendix A). Sessions lasted an average 45 minutes with students and 20 minutes with staff[2]. The interviewer took notes during the interviews and sessions were audiotaped. Following the interview, participants were informed of the purpose of the study and any questions they had were answered.

## Results

Opinions regarding the acceptability of euthanasia varied greatly. In general, passive euthanasia was seen as more acceptable than active euthanasia. Some factors that seemed to decrease people's endorsement of both active and passive euthanasia was a strong religious affiliation and a belief in the sanctity of life. Factors that

enhanced the endorsement of euthanasia included having witnessed a slow and painful death of a loved one and a self-proclaimed strong commitment to "personal autonomy" and "freedom of choice".

Almost all participants stressed that the most important aspect of euthanasia, especially active euthanasia, is that it should respect the patient's desire. Many considered that euthanasia decisions are virtually impossible to make when involving someone other than themselves, unless specifically requested either by a conscious patient or by means of some written document. According to the majority, one of the only instances when people other than the patient can legitimately make a euthanasia decision is when the removal of life support is considered for a deeply comatose individual.

Most mentioned terminal illness as a necessary condition for euthanasia, with severe pain and physical dependency increasing the acceptability of euthanasia. However, for many, more important than physical hardship and suffering, the loss of a sense of "selfhood" or of a sense of "purpose" would be the most important trigger in considering requesting euthanasia for themselves. For nearly all participants, the concepts of quality of life and human dignity are grounded in a fundamental, yet unspeakable, sense of "self".

Other than voluntariness of the request and euthanasia method, 14 influential situational factors were identified (see Table 2). They are, in no particular order: severity of physical pain, severity of psychological distress, chance for recovery, mental alertness, diagnosis, age of the patient, cost of treatment inflicted upon society,

opinions of friends and relatives of the patient, legal sanction, considerations for alternative treatments, considerations for pain-relieving treatments, time spanned by the patient's request, etiology of the disease and degree of physical dependency.

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Insert Table 2 about here.

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## Mailed Survey

### Method

Participants. Questionnaires were mailed to 2000 people in the Greater Vancouver Area. Names of potential respondents were obtained randomly from a directory of households in that area. Each respondent was mailed a cover letter, a questionnaire, and an addressed, postage-paid return envelope in the second week of May, 1994. Seventy (3.5%) of the original questionnaires were undeliverable. The return rate after the first mailing was 27%. No identifying records of participation were kept in order to preserve anonymity. Two months later, all potential respondents were sent another cover letter, questionnaire and postage-paid return envelope to maximize response rate. The return rate after the second mailing was 42.6%. Twenty-two (2.65%) of the returned questionnaires were discarded for the following reasons: 15 because more than half the questions were left unanswered; two because the respondent was under 18 years of age; and five because the questionnaire was returned after the deadline for data collection. The final sample used for statistical computation comprised 810 questionnaires, representing 42% of the deliverable questionnaires.

Fifty-five percent of the 810 respondents were males, 44% were females and 1% did not indicate gender. One hundred and seventy-six people read the active/other scenario; 210 people read the passive/other scenario; 214 people read the active/self scenario; and 210 read the passive/self scenario. To compare the composition of the four groups, two-way ANOVA's (e.g., method by person) were performed on age and religiosity, and chi-square analyses were performed on gender, education, occupation and religion. Groups were found to differ significantly on religiosity (two-way interaction; $F(1,781)=5.40$, MSE=44.54, $p<.05$, $n=781$), as well as on gender ($X^2(1)=5.54$, $p<.05$, $n=801$) and on education, $X^2(6, 797)=12.09$, $p<.05$. However, since oneway ANOVAs revealed that neither gender nor education were found to influence opinions toward euthanasia, all demographic characteristics, except religiosity, are reported for the sample as a whole in Table 3. The ANOVA table for religiosity, as well as a description of this variable for each scenario can be found in Table 4.

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Insert Tables 3 and 4 about here.

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Questionnaire. Each questionnaire first presented a scenario depicting a terminally ill patient requesting a physician's assistance in performing euthanasia (see Appendix B). Because voluntariness of the request is a crucial determinant of the acceptability of euthanasia, it was stated explicitly in each scenario that euthanasia was the patient's choice. Four different scenarios were created by manipulating two variables, namely

the person involved (e.g., "self" versus "other") and the method of euthanasia (e.g., "active" versus "passive"). In half the cases, the patient was described simply as "Chris" (e.g., "other" condition), in the other half, respondents were asked to imagine themselves as terminally ill (e.g., "self" condition). Both levels of this "person" variable were crossed with both levels of euthanasia method, namely a lethal injection (e.g., "active") or the withdrawal from life-support (e.g., "passive"). After reading the brief scenario, people were asked how acceptable the request for euthanasia was, on a scale from 1 (not at all acceptable) to 7 (absolutely acceptable).

Following this opinion question, respondents were asked to rate the importance of the 14 factors identified during the pilot work in making their euthanasia decisions. These ratings were given on a scale from 1 (not at all important) to 7 (absolutely important). A Cronbach alpha reliability analysis was performed on the ratings of the 14 situational factors and revealed a high level of internal consistency ($\underline{r}$=.885, $\underline{n}$=787).

After these factor questions, people were asked how long a patient should have been thinking about euthanasia before a request is considered acceptable. Finally, the last section documented demographic characteristics of the respondents. The literature suggested including religiosity, religion, education and age, which have proven to be most influential. Gender and occupation were included to allow discussion of the generalizability of the findings and comparisons with previous research.

For those who read scenarios involving "Chris" (e.g., "other" condition), respondents were asked to specify what gender and age they had imagined "Chris" to be. The scenarios involving "Chris" were kept gender-neutral to avoid comparisons

with the highly publicised case of Sue Rodiguez, a resident of British Columbia, who died by means of a physician-assisted suicide a few months before this survey was conducted (Rodriguez v. British Columbia, 1993). Forty-two percent of respondents had imagined Chris to be a man, 20.8% had imagined Chris to be a woman, 30.2% were undecided. The remainder of respondents either stated that Chris' gender was irrelevant or did not answer the question. Most respondents imagined Chris to be either in her 30s (49.7%) or 40s (24.7%). Few respondents said that they were undecided with regard to Chris's age (7.8%) or that age was irrelevant (1.6%).

## Results

Influence of Demographics on Acceptability of Euthanasia. The influence of age and religiosity on acceptability of euthanasia were investigated by means of Pearson product moment correlations. The first correlational analysis, performed on the sample as a whole, revealed a significant negative relationship between religiosity and acceptability of euthanasia ($r$=-.40, $p$<.01). Since groups differed in mean degree of religiosity, scenarios were then analyzed separately. In all four conditions, religiosity was found to be significantly negatively correlated with acceptability for euthanasia($p$<.01; active/other: $r$=-.48; passive/other: $r$=-.30; active/self: $r$=-.51; passive/self: $r$=-.33; all effects sizes medium to large, Cohen, 1992). Age was not found to be systematically correlated with decisions of whether to support euthanasia.

To further investigate the influence of demographics on acceptability ratings, a stepwise multiple regression of age and religiosity on opinion ratings was performed, initially on the sample as a whole. Religiosity was entered first, accounting for

approximately 16% of the variance. Age was entered second, only accounting for an additional 1% of the variance. Since groups differed in mean degree of religiosity, this analysis was repeated for each of the four scenarios individually. Religiosity, always entered first, accounted for 25% of the variance in the active/other scenario, 9% in the passive/other scenario, 27% in the active/self scenario, and 11% in the passive/self scenario. Age was entered second only in the active/other and passive/self scenarios, where it accounted for 2% of the variance in both (see Table 5).

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Insert Table 5 about here.

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Oneway ANOVAs on opinion ratings were performed for gender, education, occupation and religion on the sample as a whole. Only religion was found to have a significant effect on acceptability of euthanasia. Religion, which was reported by means of an open-ended question on the original questionnaire, was coded into four categories: No Religion, Roman Catholic, Protestant, and Other. The "Other" category included all organized religions and cults which accounted for less than 1% of respondents each (see footnote of Table 3 for a breakdown of that category). Post-hoc Neuman-Keuls pairwise comparisons revealed that Roman Catholics and respondents committed to other religions found euthanasia significantly less acceptable than Protestants (Table 6). Furthermore, Roman Catholics, respondents committed to other religions, and Protestants were all found to be significantly less accepting of euthanasia than non-committed respondents.

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Insert Table 6 about here

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Influence of Euthanasia Method on Acceptability of Euthanasia. A 2 X 2 ANOVA (e.g., method X person) was performed on the acceptability ratings provided. Twenty-three of the 810 respondents (e.g., 3%) failed to answer this question and were excluded from the analysis. Only the main effect for method of euthanasia was significant, $F(1,786)=21.266$, $p<.001$, $MSE=62.69$. A oneway ANOVA on method of euthanasia revealed that in the "other" condition, mean acceptability of passive euthanasia was significantly higher than mean acceptability for active euthanasia, $F(1,377)=10.66$, $p<.001$, $MSE=33.71$ (see Table 7 for mean acceptability of euthanasia in each scenario). As well, in the "self" condition, mean acceptability of passive euthanasia was significantly higher than mean acceptability for active euthanasia, $F(1,408)=10.55$, $p<.001$, $MSE=28.99$.

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Insert Table 7 about here.

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A chi-square analysis revealed significant differences in the distribution of acceptability responses across the active/passive dimension only, $X^2(6, 787)=22.57$, $p<.000$. For the two scenarios involving passive euthanasia, 90% of respondents found treatment withdrawal acceptable to some degree, whereas for the two scenarios involving active, 79% of respondents found a lethal injection acceptable to some

degree. Similarly, for the two scenarios involving passive euthanasia, 4% of respondent found treatment withdrawal to be "absolutely unacceptable", whereas 9% of respondents found a lethal injection to be "absolutely unacceptable" (see Table 8 for a distribution of opinions by response categories).

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Insert Table 8 about here.

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Influence of the Person Involved on Acceptability of Euthanasia. There was no main effect found for the person involved in the scenario, nor was there a two-way interaction between the two independent variables.

Relative Importance of Situational Components.

A multivariate 2 X 2 MANOVA (e.g., method by person) was performed on the importance ratings given on a 7-point scale to each of the 14 situational components listed on the questionnaires. The analysis revealed a main effect for the person variable only, Hotelling $T^2(770)=0.351$, $p<.001$.

A univariate MANOVA for the person variable was performed on the 14 importance ratings. Seven of the 14 situational components were judged significantly more important when making a decision about self than other, for both active and passive euthanasia. These situational components included: physical dependency, cost of treatment, age, opinions of friends and family, etiology, diagnosis, considerations for other pain-relieving treatments (see Table 9). Two situational components, namely physical pain and chance for recovery, were judged significantly more important when

making a decision about self than other, but only for passive euthanasia. Mental alertness was rated as significantly more important when making a decision about self also, but for active euthanasia only.

Because religiosity was found to account for an important amount of the variance in decisions about whether to support euthanasia, the 2 X 2 MANOVA (e.g., method by person) was performed a second time with religiosity as a covariate. The results remained unchanged.

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Insert Table 9 about here.

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The rank ordering of the 14 situational factors within each of the four scenarios is presented in Table 10.

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Insert Table 10 about here.

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To further clarify the influence of situational components on acceptability of euthanasia, a stepwise multiple regression of the 14 components onto acceptability ratings was performed. This analysis was only performed for the sample as a whole. Seven components were entered before the alpha=.05 limit was reached, namely psychological suffering, time spanned by the request, law, cost, mental alertness, diagnosis and age respectively. Together, they accounted for 37% of the variance in acceptability ratings (see Table 11).

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Insert Table 11 about here.

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Time spanned by the request.

In order to address the Netherlands' guideline suggesting that a request for euthanasia should be stable and enduring before it is granted, one of the questions asked respondents whether it was important that a patient had been thinking about euthanasia for some time, and how long the patient should have been thinking about it. Thirty-four percent of respondents answered that a request for euthanasia should span less than six months. Thirty percent answered that the request shoud span six months or more. Six percent of respondents answered that the time span should depend on the course of the illness, 12.5% answered that it is an individual decision and that a minimum time span cannot be specified. The remainder of the participants answered comments such as "one shouldn't think about it", "it's irrelevant", "as soon as somebody is diagnosed". Each of the latter categories accounted for less than 3% of respondents.

Clustering of Situational Components.

A series of exploratory principle component factor analyses with oblique rotation[3] were performed on the importance ratings of the 14 situational components for each scenario individually. A criterion of a factor loading of .6 or higher was used to include a variable in a factor. None of the variables loaded highly on more than one factor. The first factor analysis, performed on the active/other scenario, revealed a

two-factor structure, with the factors correlating moderately (r=.55). The first factor, which accounted for 48.5% of the variance, was mostly a grouping of symptoms experienced by the patient and treatment related components, and was labeled "internal/symptoms/treatment". The variables which loaded onto the first factor included chances for recovery, mental alertness, physical dependency, psychological suffering, physical pain, considerations for alternative treatment, considerations for pain-relieving treatments, and time spanned by the request (see Table 12 for factor loadings). The second factor, which accounted for 9.4% of the variance, was mostly a grouping components involving societal sanction and public opinion, and was labeled "external/society". Variables loading onto the second factor included etiology, age, diagnosis, opinions of friends and family, cost of treatment and legal considerations. At first glimpse, diagnosis and etiology, which are disease-related, look like they would better belong to factor 1. However, they constitute external labels that identify an illness and its origin, and represent a social convention rather than a physical experience, which may explain why they load onto the second factor.

For the passive/other scenario, a 4-factor model emerged. However, the third and fourth factors each only had one variable loading highly onto them, time spanned by the request and cost respectively. Furthermore, factors 3 and 4 correlated poorly with factors 1 and 2. A factor analysis allowing only two factors was therefore performed on the passive/other scenario, which revealed a factor structure similar to that of the active/other scenario, with time and cost loading only poorly onto factor 1 (internal/disease/treatment) and 2 (external/society) respectively. The correlation

between factor 1 and 2 was moderate (r=.37). (See Table 12 for factor loadings).

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Insert Table 12 about here.

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For the active/self scenario, a 3-factor model emerged. The first and second factors were comparable to the two factors which emerged in the "other" conditions. However three variables, namely considerations for the treatment of pain, considerations for alternative treatment and diagnosis, loaded negatively onto a third factor. The first factor was therefore labeled "internal/symptoms", the second was labeled "external/society", and the third was labeled "non-treatment". These factors were all moderately correlated with one another (r(1-2)=.43; r(1-3)=-.32; r(2-3)=-.23) (see Table 13 for loadings).

For the passive/self scenario, a three-factor model emerged as well, with all three factors being almost identical to those of the active/self scenario. The only differences were that time spanned by the request loaded onto the third rather than the first factor, and the loadings onto the third factor were positive. The factors in this condition were therefore labeled "internal/symptoms", "external/society" and "treatment". The three factors were moderately correlated with one another (r(1-2)=.33; r(1-3)=.44; r(2-3)=.29) (see Table 13 for factor loadings).

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Insert Table 13 about here.

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## General Discussion

As predicted in the first hypothesis, the findings of the current study suggest that, among the demographic variables that were investigated, religious commitment was the best predictor of euthanasia opinion, and was inversely related to acceptability of euthanasia. This finding was significant for the sample as a whole, as well as for each individual scenario taken individually, and is consistent with findings from previous research (Adams et al., 1978; Jorgenson & Neubecker, 1980; Ostheimer & Moore, 1981; Shuman et al., 1992; Singh, 1979; Wade & Anglin, 1987). This inverse relation was strongest for the two active euthanasia scenarios, suggesting that people who are strongly committed to an organized religion are less accepting of euthanasia in general, but particularly of active euthanasia.

No specific predictions were made regarding the other demographic variables, which were included in the design for exploratory purposes. Religious affiliation was the only one found to have a significant effect. Roman Catholics and people committed to other religions (e.g., Judaism, Islam, Sikh, and others) were found to be significantly less accepting of euthanasia in general than Protestants. Those three groups were further found to be significantly less accepting of euthanasia than non-religious people. These findings partly corroborate those of Pollard (1994), who found that 45% of Catholics "never" or "rarely" approved of mercy killing, compared to 28% of non-religious people, as well as those of Ostheimer and Moore (1980), who found Protestant respondents less accepting of euthanasia than non-religious people. Direct comparisons between these results is nevertheless limited because of the differences in

samples' compositions. Other studies may have failed to detect such differences due to methodological problems such as a greater degree of within-group than between-group variance (Wade & Anglin, 1987), or such as a dichotomization of the religion variable into religious versus non-religious (Singh, 1979), which may have masked possible differences between various religious affiliations.

So far, findings regarding age (Adams et al., 1978; Klopfer & Price, 1978; Slezak, 1982) and education (Pollard, 1994; Slezak, 1982) had been inconsistent, sometimes suggesting a positive correlation between acceptance of euthanasia and both of these variables. However, the current study did not find a significant influence of either of them on euthanasia opinion. A failure to detect a consistent relation between age or education and euthanasia opinion may be due to the negatively skewed distribution of the current sample. Respondents of the current survey had an older mean age than participants of other studies (Slezak, 1982), and a greater proportion had completed a university degree (current study, 36.3% compared to 28.4% in Pollard, 1994).

As predicted in the second hypothesis, passive euthanasia was judged significantly more acceptable than active euthanasia by respondents. Regardless of whether the scenarios involved "self" or "other", ending life by means of a lethal injection was judged far less acceptable than withdrawing life-support. This finding parallels opinions expressed by participants of the pilot interviews, the stance of a number of medical associations (e.g., American, British, Canadian and World Medical Associations) and legal commissions (e.g., Canadian Law Reform Commission and U.S. Presidential Commission), and the results of a number of previous studies

(Bosmann et al., 1987; Ho & Penney, 1991), which also found that active euthanasia was considered less acceptable than passive euthanasia, but only investigated this difference for conditions analogous to the "other" condition of the current survey. The difference in acceptability between active and passive euthanasia suggests that the public still perceives mercy killing as worse than treatment withdrawal (Latimer, 1991; O'Rourke, 1989; Rachels, 1975; Winkler, 1985).

The third assumption, derived intuitively from the pilot interviews, suggested that the decision-making process would differ for "self" and "other", but no specific predictions regarding how this difference may emerge were formulated. Many interviewees commented that euthanasia decisions should be left to the individual, and that decisions should not be made for others unless they were in a deep comatose state. Many stated that it would be "easier" to decide for themselves, because only the dying patient really knows what he or she is going through. The current results showed that most of the situational components listed in the questionnaire were judged significantly more important when making a decision about "self" than "other", regardless of whether active or passive euthanasia was being decided upon. Furthermore, the factor analyses revealed a more complex factor structure for "self" than "other" scenarios, which confirmed the expectation formulated in the fourth assumption, stating that the factor clusters may differ across conditions. The latter finding stands in contrast to previous findings by Wade and Anglin (1987), which suggested that a four-factor model best fit endorsement of euthanasia for both "self" and "other" in various situations. However, Wade and Anglin's (1987) "other"

condition involved parents rather than a stranger. Nevertheless, in all four scenarios of the current study, two factors consistently emerged which were comparable to two of the four factors identified by Wade and Anglin (1987). In both studies, one of the factors was a clustering of person-related variables, such as pain experience and disease symptoms, and another was a clustering of external sanction-related variables, such as financial considerations and existing laws.

The current findings that many situational components are rated as more important for "self" than for "other", and that the factor structure of these components is more complex for the "self" conditions, suggest that decisions about oneself may be more complicated to make, and may require more scrutiny, than decisions about others. Nevertheless, even though the decision-process appeared to be different for "self" and "other", this difference did not affect the outcome as measured by ratings of euthanasia acceptability. Whether respondents were making a decision about themselves or someone else, the difference in acceptability was explained by which euthanasia method was described in the scenario. No matter how much or how long people debate about this controversial issue, in the end, there are only two options: to kill/let die or not to kill/let die.

The fourth assumption also stated that some situational components may be consistently rated as more important than others, but not specific predictions were formulated with regards to what the ordering would be. Even though the rank-ordering of the situational components was slightly different across the four conditions, some components did emerge as more important than others overall. The

components considered most important overall were, in order: chance for recovery, mental alertness, considerations for alternative treatments and for pain-relieving treatment, psychological suffering and time spanned by the patient's request for euthanasia. The current study was the first to look at such ordering. During the pilot interviews, almost all participants mentioned the first three components as important considerations when deciding upon the legitimacy of a euthanasia request.

This ordering somewhat parallels the guidelines used in the Netherlands to regulate active euthanasia and assisted-suicide (see Angell, 1988). These guidelines indeed stress the importance of insuring that the patient is competent and capable of making an informed decision, that all other treatment alternatives acceptable to the patient have been tried, and that the request be stable and enduring. However, the Dutch guidelines do not specifically state that the patient should be suffering from a terminal illness, a provision which was however included in another set of guidelines proposed by the Americans Against Human Suffering organization, the political counterpart of the Hemlock Society. The Dutch guidelines also do not refer specifically to psychological suffering, but one of the ongoing debates in the Netherlands regards mandatory involvement of psychiatrist in euthanasia decisions (Huyse & Hengelveldt, 1989). Some authors advocate that mental health professionals' involvement is important in treatment withdrawal decisions to assess psychiatric problems which may affect decision-making capacities (Moldawski, 1993) or the desire to die (Hendin, 1994).

Among the least important situational components were age of the patient, legal

sanction, and cost of treatment. From an utilitarian point of view, some may consider active euthanasia and assisted-suicide more economical than prolonged life-supporting treatment, but this doctrine did not seem popular among respondents. Furthermore, the fact that legal sanction was rated as one of the least important situational components suggest that the euthanasia debate may be a moral rather than a legal one for the majority of people who answered this survey.

Even though all hypotheses and assumptions were supported, the meaningfulness of the findings is worth considering. Regarding the first hypothesis about demographic predictors of euthanasia, even though religiosity was consistently found to be inversely correlated with acceptability of euthanasia, this variable explained only a small percentage of the variance in opinions about euthanasia. Furthermore, religiosity, or religious commitment, is a complex concept which is difficult to measure. A number previous studies measured religiosity by means of a scale developed by Faulkner and DeJonc (1973), which focussed on behaviors such as church attendance and participation in church activities as indicators of strenght of religious beliefs. However, such scale was judged inappropriate for the current study. Nevertheless, measuring religiosity on a linear 9-point scale, anchored at either end by 1, "not at all committed" and 9, "absolutely committed" (Mogghadam & Vuksanovic, 1992), may not have done justice to the complexity of this concept.

Regarding religion, even though opinions of people committed to various religions were found to be statistically different, the meaningfulness of these differences may be questionable. When the mean acceptability ratings of euthanasia given by people of

various religious denominations are tied back to the categories of the scale that was presented on the questionnaire, the difference becomes one between "somewhat acceptable" and "acceptable", which may not be a practical distinction in the context of real-life decisions. Furthermore, even though many comparisons revealed significant differences, the comparisons involving the "Other religions" category should be interpreted with caution considering the heterogeneity of this group.

Regarding the second hypothesis about euthanasia methods, although treatment withdrawal was reliably found to be more acceptable than a lethal injection, the current study fails to clarify why this is so and why people feel so differently about ending life and letting life end. Moreover, the use of specific definitions for active and passive euthanasia restricts the generalizability of the current findings to other forms of euthanasia.

Regarding the third assumption about decision-making for "self" and "other", even though the findings seem to indicate that the decision-making process is different when respondents are asked to make a decision for themselves and for a stranger, this distinction might be artificial. People responding to the "self" scenarios may have found it difficult to imagine themselves as terminally ill. A number of people who were interviewed during the pilot phase of this project indeed commented that it was very hard for them to imagine themselves in such a situation, and some refused to answer questions pertaining to such a hypothetical situation. Furthermore, both respondents who read the "other" and "self" scenarios may have based their responses on their personal experience with death or euthanasia involving someone close to

them. Since experience with death and euthanasia was not documented, and since no assessment of the ecological validity of the the "person" manipulation was included in the design, it is difficult to conclude whether the findings reflect a real difference between the decision process governing decisions about "self" and about "other", and whether they reflect real-life decision-making about "self" and "other". The finding that the person variable did not influence ratings of euthanasia acceptability suggests that the process involved in making euthanasia decisions for "self" and "other" may not be different.

Finally, regarding the fourth assumption about the importance of situational components, even though some components emerged as consistently more important than others, few factors were rated as unimportant. This suggests that euthanasia decisions are multifaceted, and reaching a consensus regarding appropriate guidelines for the regulation of active euthanasia and assisted-suicide may be difficult. Furthermore, even though the situational components clustered into meaningful factors, those factors explained less than half of the variance in acceptability ratings of euthanasia.

Even though many predictors of euthanasia decisions were identified by the current study, it was impossible to combine them all in a single model to see how much of the variance in euthanasia opinions they would account for altogether. This could be clarified by future research. Among the influencial demographic variables that were identified, the influence of religious affiliation needs to be further investigated. One of the major challenges posed by such investigation is finding a large and diversified

enough sample, and best results may be achieved by means of cross-cultural studies. Future studies could also include other determinants of euthanasia attitudes such as experience with death and euthanasia, or could survey people with various degrees of involvement in palliative treatment of the terminally ill. Experience with death and dying patients has been found to influence euthanasia decisions to some extent (Anderson & Caddell, 1993; Shuman et al., 1992; Slezak, 1982), and seems to have colored people's responses to the interviews. Most interviewees who had witnessed someone's slow and painful death, or who had participated in treatment withdrawal decisions for deeply comatose individuals, expressed strong pro-euthanasia attitudes. Questions about death and euthanasia experience were excluded from the current questionnaire because of the lack of opportunity for individual debriefing. Some interviewees became very emotional when discussing these issues in person, and it was not deemed appropriate to pose these questions by means of an impersonal questionnaire. Finally, now that important situational components have been identified, their relative importance could be further investigated by means of systematic combinations within euthanasia vignettes.

As Veatch (1976) once remarked, the debate surrounding euthanasia is an ethical rather than a medical one which involves the community at large rather than medical professionals only. Despite their limitations, studies such as this one, which investigate the criteria that influence people's view of euthanasia, are an important step in understanding the acceptability of euthanasia and in setting guidelines to protect the rights of both the patient and the community.

## Endnotes

1. Specific definitions of active and passive euthanasia were used because the pilot work revealed that few people knew about the distinction between those two methods of euthanasia. The definitions were based on a broad review of the literature.

2. The difference in duration was meant to accomodate both students' research credit requirements and staff breaks. Both students and staff expressed a range of opinions, but their responses did not seem to have been affected by the time constraints.

3. An oblique rotation was performed since there is no reason to believe that factors are orthogonal (Cooper, 1983).

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Table 1

Demographic Characteristics of Interview Participants (N=40)

| Variable | n | Mean | SD |
|---|---|---|---|
| Age: | | 24.75 | 9.26 |
| < 20 | 19 (47.5%) | | |
| 20s | 11 (2.75%) | | |
| 30s | 4 (10%) | | |
| 40s | 5 (12.5%) | | |
| 50s | 1 (2.5%) | | |
| Gender: | | | |
| Female | 27 (67.5%) | | |
| Male | 13 (32.5%) | | |
| Education: | | | |
| Some university | 32 (80%) | | |
| Undergraduate degree | 7 (17.5%) | | |
| Graduate degree | 1 (2.5%) | | |
| Religion: | | | |
| None | 29 (72.5%) | | |
| Roman Catholic | 1 (2.5%) | | |
| Jewish | 1 (2.5%) | | |
| Protestant | 9 (22.5%) | | |

Table 1 (continued)

Demographic Characteristics of Interviews Participants (N=40)

| Variable | n | Mean | SD |
|---|---|---|---|
| Religiosity[1] | 40 | 1.05 | 1.78 |
| Opinion[2] | | | |
| "not at all acceptable" | 5 (12.5%) | | |
| "somewhat acceptable" | 6 (15.0%) | | |
| "acceptable" | 1 (2.5%) | | |
| "very acceptable" | 6 (15.0%) | | |
| "absolutely acceptable" | 20 (51.3%) | | |

1 Measured on a scale from 1 "not at all committed" to 9 "absolutely committed" (Moggadham & Vuksanovic, 1992)..

2 "How acceptable was Sue Rodriguez's request for a physician-assisted suicide?". One person (2.5%) was not asked and one (2.5%) said she did not have enough information to answer.

Table 2

Situational Components Identified as Potential Influence on Euthanasia Decision

1. Severity of the physical pain the patient is in.
2. Degree of physical dependency of the patient (e.g., being bedriden, fed).
3. Mental alertness (e.g., is the patient competent, able to make an informed decision.
4. Chance for recovery and how long the patient is likely to live.
5. Current laws about euthanasia and assisted-suicide.
6. Cost of life-support treatment.
7. Severity of psychological suffering (e.g., distress, depression, etc.).
8. Age of the patient.
9. Etiology of the disease.
10. Considerations given to alternative treatment.
11. Considerations given to other pain-relieving treatment.
12. Time spanned by the request (e.g., not a spur of the moment decision).
13. Diagnosis and how much is known about the disease.
14. Opinions of friends, family members or people emotionally tied to the patient.

Table 3

Demographic Characteristics of Survey Participants (N=810)

| Variable | n | Missing |
|---|---|---|
| Gender: | | 9 (1.1%) |
| Females | 359 (44.3%) | |
| Males | 442 (54.6%) | |
| Education: | | 13 (1.6%) |
| Less than High School | 61 (7.5%) | |
| High School Diploma | 166 (20.5%) | |
| Professional Diploma/Trade School | 177 (21.8%) | |
| Some University | 99 (12.2%) | |
| Undergraduate Degree | 143 (17.7%) | |
| Graduate Degree | 151 (18.6%) | |
| Occupation: | | 25 (3.1%) |
| Homemaker | 29 (3.6%) | |
| Clerical | 61 (7.8%) | |
| Manual/Trade | 52 (6.4%) | |
| Managerial/Sales | 112 (13.8%) | |
| Professional | 296 (36.5%) | |
| Military/Peace Officer | 36 (4.6%) | |
| Retired | 162 (20.6%) | |
| Unemployed | | 10 (1.3%) |

Table 3 (continued)

Demographic Characteristics of Survey Participants (N=810)

| Variable | n | Missing |
|---|---|---|
| Occupation: | | |
| Student | 27 (3.3%) | |
| Religion: | | 36 (4.4%) |
| None | 300 (37.0%) | |
| Roman Catholic | 87 (10.7%) | |
| Other[1] | 60 (7.4%) | |
| Protestant | 309 (38.1%) | |
| Personal Beliefs | 18 (2.2%) | |
| Age: | | 11 (1.4%) |
| 20s or less | 97 (12%) | |
| 30s | 187 (23.1%) | |
| 40s | 189 (23.3%) | |
| 50s | 113 (14%) | |
| 60s | 90 (11.1%) | |
| 70s | 98 (12.1%) | |
| 80s and more | 25 (3.1%) | |

1. Comprises: Judaism, Sikh, Advantist, Buddhist, Born Again Christian, Orthodox, Taoist, Islam, Pentecostal, Karma, ACC, Jehovah's Witness, Church of England, Native Spirituality, Mormon.

Table 4

a) Two-way ANOVA Table: Religiosity by Euthanasia Method and Person Involved

| Source of Variation | DF | MS | F | p |
|---|---|---|---|---|
| Method | 1 | .077 | .009 | .923 |
| Person | 1 | 1.941 | .235 | .628 |
| Method by Person | 1 | 44.541 | 5.399 | .020 |
| Explained | 3 | 15.264 | 1.850 | .137 |
| Residual | 778 | 8.250 | | |
| Total | 781 | 8.277 | | |

b) Religious Commitment

| Sample | Mean | SD | n | Missing |
|---|---|---|---|---|
| All | 3.84 | 2.88 | 782 | 28 |
| Active/Other | 4.15 | 2.77 | 169 | 7 |
| Passive/Other | 3.66 | 2.92 | 200 | 10 |
| Active/Self | 3.57 | 2.80 | 207 | 7 |
| Passive/Self | 4.03 | 2.98 | 206 | 4 |

Table 5

Summary for Stepwise Regression Analysis for Demographics Predicting Acceptability of Euthanasia (N=810)

| Variable | B | SE B | Beta | $R^2$ |
|---|---|---|---|---|
| Overall | | | | |
| Religiosity | -.253 | .020 | -.417 | .16 |
| Age | .011 | .004 | .103 | .18 |
| Active/Other | | | | |
| Religiosity | -.364 | .050 | -.494 | .25 |
| Age | .019 | .009 | .147 | .27 |
| Passive/Other | | | | |
| Religiosity | -.155 | .035 | -.299 | .09 |
| Active/Self | | | | |
| Religiosity | -.361 | .043 | -.517 | .27 |
| Passive/Self | | | | |
| Religiosity | -.157 | .031 | -.344 | .11 |
| Age | .012 | .005 | .150 | .13 |

Notes. For all the variables entered, $p<.05$ or greater. $R^2$ is cumulative.

Table 6

Influence of Religion on Acceptability Ratings

a) ANOVA Table

| Source of Variance | DF | SS | F | p |
|---|---|---|---|---|
| Between Groups | 3 | 167.80 | 19.74 | .000 |
| Within Groups | 747 | 2116.24 | | |
| Total | 750 | | | |

b) Mean Opinion Ratings for Each Religion Category

| Category | Mean | SD | N |
|---|---|---|---|
| Roman Catholic | $5.01^{a,c}$ | 2.08 | 85 |
| Other Religions | $5.13^{b,d}$ | 2.11 | 55 |
| Protestant | $5.62^{a,b,e}$ | 1.86 | 302 |
| No Religion | $6.31^{c,d,e}$ | 1.24 | 304 |

Notes. Means that share a superscript are significantly different at the level $p<.05$ or greater.

Table 7

Two-way ANOVA: Acceptability by Euthanasia Method and Person Involved

| | Person Involved | |
|---|---|---|
| Method | Other | Self |
| Active | 5.44 (2.04)[a] | 5.58 (1.91)[b] |
| | n=176 | n=214 |
| Passive | 6.04 (1.53)[a] | 6.11 (1.35)[b] |
| | n=210 | n=210 |

Note. Values enclosed in parentheses represent standard deviations.

Means sharing the same superscript within a column are significantly different at $p<.001$ or greater. Acceptability ratings were on a scale from 1 "not at all acceptable" to 7 "absolutely acceptable.

Table 8

Percentage of Respondents in Each Category of Acceptability for Active and Passive Euthanasia (N=787)

| Category | Active | Passive |
|---|---|---|
| 1 "absolutely unacceptable" | 9.2 | 3.7 |
| 2 "not acceptable" | 6.6 | 2.2 |
| 3 "somewhat unacceptable" | 0.8 | 1.0 |
| 4 "undecided" | 4.0 | 3.2 |
| 5 "somewhat acceptable" | 7.9 | 7.8 |
| 6 "acceptable" | 29.3 | 30.4 |
| 7 "absolutely acceptable" | 42.2 | 51.7 |

Notes. $X^2(6)=22.57$, $p<.001$.

Table 9

Mean Importance Ratings of Situational Components in Each Condition

| Factor | Other | | Self | |
|---|---|---|---|---|
| | Active (n=176) | Passive (n=210) | Active (n=214) | Passive (n=210) |
| Physical Pain | 4.94 (2.18) | 4.95 (2.16)[b] | 5.42 (1.83) | 5.62 (1.66)[b] |
| Physical Dep. | 5.00 (2.12)[a] | 4.97 (2.08)[b] | 5.69 (1.69)[a] | 5.87 (1.51)[b] |
| Mental Alert. | 5.60 (1.98) | 5.80 (1.72)[b] | 5.72 (1.71) | 6.08 (1.33)[b] |
| Chance for Rec. | 5.71 (1.92) | 5.80 (1.73)[b] | 6.00 (1.65) | 6.16 (1.40)[b] |
| Legal Sanction | 3.97 (2.05) | 4.25 (2.14) | 4.02 (1.98) | 4.11 (2.04) |
| Cost | 3.57 (2.14)[a] | 3.98 (2.15)[b] | 5.11 (1.83)[a] | 5.17 (1.77)[b] |
| Psych. Suff. | 5.55 (1.79) | 5.77 (1.53) | 5.44 (1.64) | 5.72 (1.42) |
| Age | 2.98 (1.91)[a] | 3.10 (1.94)[b] | 3.93 (2.00)[a] | 3.96 (2.07)[b] |
| Friends/Family | 3.88 (1.98)[a] | 3.95 (1.97)[b] | 4.76 (1.84)[a] | 4.95 (1.61)[b] |
| Etiology | 2.69 (2.04)[a] | 3.24 (2.24)[b] | 3.93 (2.16)[a] | 4.09 (2.16)[b] |
| Alternative Tx | 5.47 (1.85) | 5.65 (1.55) | 5.65 (1.56) | 5.87 (1.25) |
| Diagnosis | 4.10 (2.33)[a] | 4.43 (2.25)[b] | 5.50 (1.91)[a] | 5.84 (1.71)[b] |
| Tx of Pain | 5.17 (1.92)[a] | 5.38 (1.82)[b] | 5.88 (1.31)[a] | 6.00 (1.28)[b] |
| Time Span | 5.53 (1.94) | 5.75 (1.62) | 5.35 (1.91) | 5.68 (1.53) |

Notes. Numbers in parentheses indicate standard deviations. Means that share superscript within a row are significantly different from each other at $p<.05$ level or greater.

Table 10

Rank Ordering of Situational Components in Each Scenario

| Other | | Self | |
|---|---|---|---|
| Active | Passive | Active | Passive |
| Chances for recovery | Chances for recovery | Chances for recovery | Chances for recovery |
| Mental alertness | Mental alertness | Treatment of pain | Mental alertness |
| Psych. suffering | Psychological suffering | Mental alertness | Treatment of pain |
| Time | Time | Physical dependency | Physical dependency |
| Alternative treatment | Alternative treatment | Alternative treatment | Alternative treatment |
| Treatment of pain | Treatment of pain | Diagnosis | Diagnosis |
| Physical dependency | Physical dependency | Psychological suffering | Time |
| Physical pain | Physical pain | Physical pain | Psych. suffering |
| Diagnosis | Diagnosis | Time | Physical pain |
| Law | Law | Cost | Cost |
| Friends and family | Cost | Friends and family | Friends and family |
| Cost | Friends and family | Law | Etiology |
| Age | Etiology | Age | Law |
| Etiology | Age | Etiology | Age |

Table 11

Summary for Stepwise Regression Analysis for Situational Components Predicting Acceptability of Euthanasia (N=810)

| Situational Factor | B | SE B | Beta | $R^2$ |
|---|---|---|---|---|
| Psychological suffering | .391 | .041 | .362 | .26 |
| Time spanned by request | .229 | .032 | .235 | .30 |
| Law | -.157 | .026 | -.188 | .33 |
| Cost | .124 | .027 | .150 | .34 |
| Mental alertness | .140 | .038 | .138 | .35 |
| Diagnosis | -.071 | .027 | -.090 | .36 |
| Age | -.063 | .028 | -.074 | .36 |

Notes. All variables entered are significant at $p<.05$ or greater.

Table 12

Factor Analyses on Importance Ratings of Situational Components: Two-Factor Model for "Other" Conditions

| Variable | Factor 1 | Factor 2 |
|---|---|---|
| Chance for recovery | .918 (.803) | |
| Mental alertness | .843 (.677) | |
| Physical dependency | .829 (.753) | |
| Physical pain | .793 (.671) | |
| Psychological suffering | .847 (.759) | |
| Alternative treatment | .832 (.590) | |
| Treatment of pain | .764 (.543) | |
| Time spanned | .710 | |
| Heredity v. Lifestyle | | .755 (.744) |
| Age | | .639 (.634) |
| Diagnosis | | .625 (.730) |
| Family/Friends | | .656 (.500) |
| Cost | | .663 |
| Law | | .565 (.665) |
| % variance explained | 48.5 (36.9) | 9.4 (10.9) |

Notes. The first loadings are the results of the factor analysis for the active/other condition. The loadings in parentheses are for the passive/other condition. The correlations between factor 1 and 2 are: r=.545 (r=.371).

Table 13

Factor Analyses on Importance Ratings of Situational Components: Three-Factor Model for "Self" Conditions

| Variable | Factor 1 | Factor 2 | Factor 3 |
|---|---|---|---|
| Chance for recovery | .825 (.758) | | |
| Mental alertness | .820 (.831) | | |
| Physical dependency | .803 (.867) | | |
| Physical pain | .786 (.774) | | |
| Psychological suffering | .788 (.740) | | |
| Alternative treatment | | | -.735 (.819) |
| Treatment of pain | | | -.829 (.842) |
| Time spanned | .549 | | (.628) |
| Heredity v. Lifestyle | | .740 (.763) | |
| Age | | .748 (.674) | |
| Diagnosis | | | -.752 (.664) |
| Family/Friends | | .599 (.611) | |
| Cost | (.579) | .695 | |
| Law | | .632 (.664) | |
| % variance explained | 41.3 (40.4) | 10.4 (10.0) | 8.4 (8.3) |

Notes. The first loadings are for the active/self scenario. The loadings in parentheses are for the passive/self condition. Correlations between factor 1, 2 and 3 are: r(1-2)=.433, r(1-3)=.-321, r(2-3)=-.234; (r(1-2)=.331, r(1-3)=.446, r(2-3)=.291).

Appendix A

Euthanasia Semi-Structured Interview

This interview has been designed to find out about people's ideas and attitudes toward euthanasia. As I proceed with the questions, feel free to express any view you have regarding the issue. There is no right or wrong answer. I am interested in knowing what you think and how you feel with regards to euthanasia.
Your answers will be transcribed as we go along and will be taped to ensure that I do not miss any important information.

Your participation is VOLUNTARY: you are free to refrain from answering questions that make you uncomfortable and to withdraw at any time.

Your participation is ANONYMOUS: your name or any other information that could lead to your identification will not appear on the interview transcript. Nobody else beside the interviewer will have access to the audiotapes.

Your participation is CONFIDENTIAL: in a publication or presentation, results will be discussed as group trends and the data will be locked away once the results are computed.

Definition

Q. What does "euthanasia" mean to you?
Q. How would you describe euthanasia?
R[1]. Generally, euthanasia partly means the ending of life before natural death occurs.

Q. To what extent do you think euthanasia is acceptable?

Distinction between voluntary/nonvoluntary

Q. Who can ask for euthanasia or make a decision as to whether euthanasia can be performed?
R. Often a distinction is made between cases of voluntary euthanasia, when a conscious patient requests it, and cases of nonvoluntary euthanasia, when somebody else requests it for a patient.

---

1. The "R" indicates information that will be given to the subjects to either probe them when they are unable to come up with an answer spontaneously or to debrief them during the course of the interview.

Q. Under which conditions can somebody else request euthanasia for the patient?

R. To this date, nonvoluntary euthanasia is sometimes requested by people other than the patient in cases of "brain death" or prolonged coma.

Q. Who could request it other than the patient directly concerned?

R. In Canada, the law suggests that the physician should take the final decision. In the States, the decision is left to relatives and close friends of the patient.

Q. To what extent do you think euthanasia requested by the patient is acceptable?
Q. To what extent do you think euthanasia not directly requested by the patient is acceptable?

Distinctions active/passive

Q. Do you know of different types/kinds of euthanasia?

Q. What about active and passive euthanasia: have you heard such terms before?
Q. What do they mean to you?

R. Passive euthanasia is generally considered to be an act that lets nature run its course, for example, when life-sustaining treatment is foregone. Active euthanasia is generally conceived as an action that terminates life prematurely.

Q. Do you see similarities or differences between the two? If so, what are they?

R. Often people think of passive euthanasia as an omission (e.g., withdrawing treatment) and of active euthanasia as a commission (e.g., injecting a lethal drug).

Q. Have you heard of physician-assisted suicide?
Q. What does it mean to you?

Q. Would you draw a distinction between active euthanasia and physician-assisted suicide?

R. Some people have suggested that active euthanasia involves the final action being performed by the physician and that physician-assisted suicide involves the final action being performed by the patient.

Q. Ethically/morally, do you think there are differences between active euthanasia, passive euthanasia and physician-assisted suicide?

Q. Legally, do you think there is a difference between active euthanasia, passive euthanasia and physician-assisted suicide?

R. In Canada,the law allows passive euthanasia only. In the Netherlands, active euthanasia is permissible only under certain specific conditions.

Q. Do you think there is a difference in terms of the responsibility or duty of the physician with regard to active euthanasia, passive euthanasia and physician-assited suicide?

Q. How acceptable do you think passive euthanasia is?

Q. How acceptable do you think active euthanasia is?

Q. How acceptable do you think physician-assisted suicide is?

Distinction between various means/methods (e.g., treatment withdrawal, injection)

Q. Do you know of different means of euthanasia?
Q. Do you know of different ways to end life medically?

R. Some examples include withdrawing food an water, withdrawing a respirator or dialysis, injecting a drug, prescribing an overdose of pills, etc. Some non-medical methods include gunshots or carbon-dioxide asphixia.

Q. Have you ever heard of ordinary and extraordinary means?
Q. What do they mean to you?
Q. How are they similar or different?

R. Ordinary means are sometimes considered to include basic survival care, such as feeding and hydrating, whereas extraordinary means are sometimes considered to be high technology medical interventions, such as blood dialysis (e.g., filtering out waste products from the blood stream).

Q. How acceptable do you think withdrawal of ordinary means is?
Q. How acceptable do you think withdrawal of extraordinary means is?

Media influence

Q. Are there euthanasia cases you are familiar with or have heard about?
Q. Have you read in the paper/heard on the radio/seen on TV news about euthanasia cases?

R. What about the Sue Rodriguez case? (A 42-year-old mother of one who suffers from an incurable illness which will likely result in the loss of her ability to swallow, speak, move or even breathe without assistance, and which will almost certainly result in her being confined to bed and dying. She wishes to remain alive only so long as she has the capacity to enjoy life. When this will no longer be possible, she wishes to die, but by then will be unable to terminate her own life without assistance. Therefore, she recently sought court approval to get a physician to help her terminate her life.)

Q. What is your opinion regarding this/those case(s)?

Q. Do you agree with the final judgement(s)?

R. For example, in the Sue Rodriguez appeal, part of the final judgement, which denied her the right to a physician-assisted suicide by a slight majority, was justified on the grounds that for her to have the right to a physician-assisted suicide would entail criminal responsibility for the person helping her.

Q. Do you think the media has influenced the final judgement(s)?
Q. Do you think the media has influenced your opinion about the case(s)?

Q. How acceptable do you think it would be for Sue Rodriguez to be granted the right to a physician-assisted suicide?

Related terms

Here is a list of terms that you might have come across at some point while reading the paper or watching the news. I would like you to tell me what they mean to you:

-human dignity (R. capacity for independent living, feeding, grooming, etc.)
-autonomy (R. the right to make choices independently)
-right to privacy (R. the right to refuse invasive treatment)
-Living Wills (R. documents people can sign to refuse life-sustaining devices).

Euthanasia/Death personal experience

Q. In your personal life, have you had to deal with euthanasia?
Q. Who was involved?
Q. What were the circumstances?
Q. How long ago was it?
Q. Has it influenced your attitude toward euthanasia?

Q. Have you had to deal with death in general?
Q. Who was involved?
Q. What were the circumstances?
Q. How long ago was it?
Q. Has it influenced your attitude toward euthanasia?

Q. Imagine a loved one with a terminal illness. What condition would that person have to find herself in in order for you to start considering euthanasia as an acceptable option?

Q. Imagine yourself with a terminal illness. What condition would you have to find yourself in in order to start considering requesting euthanasia?

Q. How important is religion in your life?
Q. What are your beliefs?

Q. How committed do you consider yourself to be?

Q. Now that we have been discussing euthanasia for [ ] minutes, is there anything you would like to add about the subject, ideas you have not had a chance to express so far?

Q. What do you think has had the greatest influence on your attitude toward euthanasia?

(Record age, gender, religion, religious commitment, education, and occupation).

# SIMON FRASER UNIVERSITY

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Telephone: (604) 291-5945
Fax: (604) 291-3427

May 18th 1994

Dear ,

In the past few months, euthanasia, or "mercy killing", has received a lot of attention across Canada, particularly in British Columbia. With the increase in our society's capacity to prolong life by means of medical technology, some suggest that this capacity should be accompanied by a right to refuse this prolongation. We are conducting a survey of peoples' attitudes about this important matter. Any change in the law has serious implications for Canadians, so it is important that the opinion of the public be heard. This questionnaire was designed to get a better understanding of what people think of euthanasia or "mercy killing". In order to get a representative sample of the population, it is important that a very large number of people fill out and return this questionnaire. We encourage you to take a few minutes to read through and answer this questionnaire.

At this point, you may or may not have a clear idea of your position on euthanasia or "mercy killing". For many, it is still a grey area. Recent events have triggered talks about the amendment of euthanasia laws and about the establishment of guidelines for its regulation. Therefore, it is very important for us to find out what you have to say.

Your name was randomly selected from the Vancouver telephone directory. Even though your name and address appear on this letter, it is not on the questionnaire. Therefore, this survey is strictly anonymous: we will have no way of identifying you from your survey answers. Moreover, the results will always be discussed as group trends, making it impossible for anyone to identify your particular answers.

Again let us stress how important it is for the success of this project that you answer this questionnaire. It will take only 10 to 15 minutes of your time and will greatly benefit our understanding of people's feelings towards a very controversial issue.

If you have any questions, or would like to get a summary of the results, please call us at 291-5945. Thank you very much for your time and cooperation.

Marie Achille
Research Associate
Law and Psychology Laboratory

Dr. James R. P. Ogloff
Associate Chair
Department of Psychology

# SIMON FRASER UNIVERSITY

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Telephone: (604) 291-5945
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July 4th 1994

Dear ,

A few weeks ago, you received a survey about euthanasia, or "mercy killing". We are now proceeding with a second mailing as a reminder that it is still time for you to voice your opinion about euthanasia, or "mercy killing", and to participate to our study. This questionnaire has been designed to get a better understanding of people's attitudes toward euthanasia. Recent events have triggered talks about the amendment of euthanasia laws and about the establishment of guidelines for its regulation. Since any change in the law has serious implications for Canadians, it is important that the opinion of the public be heard. Therefore, it is very important for us to find out what you have to say. In order to get a representative sample of the population, it is important that a very large number of people fill out and return this questionnaire.

IF YOU HAVE ALREADY FILLED AND RETURNED the questionnaire, please do not fill it again. However, feel free to pass it along to someone you think might be interested in completing it. Let us take this opportunity to thank you for your time and interest. Your participation is essential to the success of this project!

IF YOU HAVE NOT FILLED AND RETURNED the questionnaire yet, we encourage you to take a few minutes to read through and answer this questionnaire. Please, only fill and return one copy of the questionnaire. Again let us stress how important it is for the success of this project that you participate. It will take only 10 to 15 minutes of your time and will greatly benefit our understanding of people's feelings towards a very controversial issue. Make sure you fill both sides of the two pages.

Your name was randomly selected from the Vancouver telephone directory. Even though your name and address appear on this letter, it is not on the questionnaire. Therefore, this survey is strictly anonymous: we will have no way of identifying you from your survey answers. Moreover, the results will always be discussed as group trends, making it impossible for anyone to identify your particular answers.

If you have any questions, or would like to get a summary of the results, please call us at 291-5945. Thank you very much for your time and cooperation.

Marie Achille
Research Associate
Law and Psychology Laboratory

Dr. James R. P. Ogloff
Associate Chair
Department of Psychology

EUTHANASIA SURVEY
Law and Psychology Laboratory
Simon Fraser University

PLEASE READ the following paragraph and ANSWER the questions below.

*Chris is a single parent of one. Chris suffers from a terminal illness which will likely result in the loss of the ability to swallow, speak, move, or even breathe without assistance, and which will almost certainly result in Chris being confined to bed and being maintained on life-support before dying. Chris wishes to remain alive only so long as life can be enjoyed. When Chris reaches the point when life cannot be enjoyed anymore, Chris also will be unable to commit suicide alone, and Chris wishes to have a physician's assistance in getting an injection of a lethal drug which will terminate Chris' life within a few hours of its administration.*

Based on this excerpt, how acceptable do you think it would be for Chris to have access to a physician's assistance to end life by injection of a lethal drug?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely unacceptable | not acceptable | somewhat unacceptable | undecided | somewhat acceptable | acceptable | absolutely acceptable |

This excerpt was purposefully left vague to provide flexibility for your responses. Many factors often come into play when we try to make up our minds about a controversial issue. You will find below some other information that may influence your opinion about Chris' situation. For each of the statements, PLEASE CIRCLE THE NUMBER that indicates how much the information influences your opinion about Chris' situation.

1. How important is it to know about the intensity and nature of the physical pain that Chris is in (e.g., how intense it is, whether it is continuous or transient, whether it can be controlled with medication, etc.)?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

2. How important is it to know about Chris' degree of physical dependency (e.g., Chris' potential inability to feed and groom independently)?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

3. How important is it to know about Chris' degree of mental alertness, and whether Chris is of sound mind?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

4. How important is it to know about Chris' chances for recovery and how much longer Chris is expected to live?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

5. How important is it to take into account the current laws about euthanasia or "mercy killing" and a possible penalty assigned by a court of law?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

6. How important is it to take into account the financial cost that Chris' treatment represents for Chris' family and for society?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

7. How important is it to know about the psychological suffering that Chris may be experiencing (e.g., depression, distress, and anxiety)?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

8. How important is it to take into account Chris' age?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

9. How important is it to take into account the opinions of people who are emotionally tied to Chris, such as close friends and family?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

10. How important is it to know whether Chris' illness is hereditary or if it results from a lifestyle choice known to promote the risk for certain diseases?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

11. How important is it to know how much consideration has been given to alternative treatments?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

12. How important is it to know which illness Chris suffers from?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

13. How important is it to know how much consideration has been given to treatments that will relieve pain and suffering?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

14. How important is it for Chris to have spent a long time thinking about having a physician's help in getting a lethal injection to end life?

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| absolutely not important | not important | somewhat unimportant | undecided | somewhat important | important | absolutely important |

How long should Chris have been thinking about whether to end life? ___ month(s)

DEMOGRAPHIC INFORMATION

**With a survey like this one, it is important for us to keep track of the demographic characteristics of our sample. Please answer the following questions, remembering that all the information you provide will remain strictly anonymous and confidential.**

1. Age:___

2. Sex (please circle one): female male

3. Highest level of education obtained (please circle one):
   - less than high school
   - high school diploma
   - professional diploma
   - some undergraduate training
   - undergraduate degree
   - graduate degree
   - other, please specify:_____

4. Occupation (please circle one):
   - homemaker
   - clerical
   - manual labor
   - managerial
   - professional
   - teaching
   - military
   - retired
   - unemployed
   - student
   - other, please specify: _____

5. What religion, if any, do you consider yourself committed to?_____

6. Please rate on the scale below how committed to your religion, if any, you consider yourself to be to (please circle one of the numbers):

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|---|---|---|---|---|---|---|---|---|
| not at all committed | | | | | | | absolutely committed | |

AT THIS POINT, please answer the last 2 questions without going back and making any changes to any of your previous answers.

1. Did you think that Chris was (please circle one):
   - a man
   - a woman
   - undecided

2. How old did you think Chris was (please circle one)?
   - 20's
   - 30's
   - 40's
   - 50's
   - older than 50
   - undecided

THANK YOU VERY MUCH, your contribution is very helpful to us. Please return this questionnaire in the stamped and addressed envelope provided. In case you have lost the envelope but are still willing to return the questionnaire, please send it to:

James R.P. Ogloff
Law and Psychology Laboratory
Simon Fraser University
Burnaby, B.C.
V5A 1S6 (604) 291-5945

Other scenarios

PASSIVE/OTHER SCENARIO

*Chris is a single parent of one. Chris suffers from a terminal illness which will likely result in the loss of the ability to swallow, speak, move, or even breathe without assistance, and which will almost certainly result in Chris being confined to bed and being maintained on life-support before dying. Chris wishes to remain alive only so long as life can be enjoyed. When Chris reaches the point when life cannot be enjoyed anymore, Chris also will be unable to commit suicide alone, and Chris wishes to have a physician's assistance in turning off life-support equipment which will let Chris' illness run its course.*

Based on this excerpt, how acceptable do you think it would be for Chris to have access to a physician's assistance to let the illness run its course by turning off life-support equipment?

ACTIVE/SELF SCENARIO

*Imagine for a moment that you are a single parent of one. Imagine also that you are suffering from a terminal illness which will likely result in the loss of your ability to swallow, speak, move, or even breathe without assistance, and which will almost certainly result in you being confined to bed and being maintained on life-support before dying. You wish to remain alive only so long as life can be enjoyed. When you reach the point when life cannot be enjoyed anymore, you also will be unable to commit suicide alone, and you wish to have a physician's assistance in getting an injection of a lethal drug which will terminate your life within a few hours of its administration.*

Based on this excerpt, how acceptable do you think it would be for you to have access to a physician's assistance to end life by injection of a lethal drug?

PASSIVE/SELF SCENARIO

*Imagine for a moment that you are a single parent of one. Imagine also that you are suffering from a terminal illness which will likely result in the loss of your ability to swallow, speak, move, or even breathe without assistance, and which will almost certainly result in you being confined to bed and being maintained on life-support before dying. You wish to remain alive only so long as life can be enjoyed. When you reach the point when life cannot be enjoyed anymore, you also will be unable to commit suicide alone, and you wish to have a physician's assistance in turning off life-support equipment which will let your illness run its course.*

Based on this excerpt, how acceptable do you think it would be for you to have access to a physician's assistance to let the illness run its course by turning off life-support equipment?