National Comparisons of Euthanasia Opinion Polls

by

Michelle L. Beauchamp

A Thesis Submitted

to the Faculty of Graduate Studies

in Partial Fulfillment

of the Requirements for the Degree of

Master of Science

Department of Family Studies

University of Manitoba

Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION PAGE

National Comparisons of Euthanasia Opinion Polls

BY

Michelle L. Beauchamp

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree of Master of Science

I hereby declare that I am the sole author of this thesis.

I authorize the University of Manitoba to lend this thesis to other institutions or individuals for the purpose of scholarly research.

Michelle Beauchamp

I further authorize the University of Manitoba to reproduce this thesis by photocopying or by other means, in total or in part, at the request of other institutions or individuals for the purpose of scholarly research.

Michelle Beauchamp

Abstract

This research project examined changing public opinions towards euthanasia in the United States and Canada. The method was a secondary analysis of the American General Social Survey (1982, 1988, 1991, 1993, and 1994) and the Canadian Gallup Poll (1984, 1990, and 1991). The sample consisted of 4,023 telephone interviews with Canadians and 35, 284 with people from the United States. Seven variables were examined in relation to euthanasia, including age of respondent, gender, income, education, religious affiliation, community size, and marital status. The results indicated that Canadians were not more accepting of euthanasia than Americans. Further results show that in Canada and the United States attitudes toward euthanasia were unrelated to gender, income, community size, and marital status. In Canada and the United States younger individuals were more accepting of euthanasia than other age groups. In Canada, Jews were less positive towards euthanasia than the other religions, but in the United States Jews were the most positive. Further research is necessary to test multivariate predictors of euthanasia opinions.

Acknowledgments

I extend my gratitude and appreciation to the members of my committee: Dr. C. Harvey, Dr. J. Bond, and Dr. B. Payne for their pertinent comments and guidelines, and willingness to assist me in the successful completion of this thesis.

I am deeply indebted to Dr. C. Harvey who has played an essential role as my advisor. Dr. Harvey has been a source of integrity, high academic standards and confidence for me. I am sincerely grateful.

I am thankful to my parents and my husband, for their patience, encouragement, and guidance which have permitted me to persevere.

Finally, I would like to thank my grandmother who brought this topic to my attention on a personal level. She had always encouraged and guided me.

Table of Contents

List of Tables

National Comparisons of Euthanasia Opinion Polls

Chapter 1

Introduction

More than ever people in Canada are debating euthanasia. As people get older they are more likely to have incurable diseases, which are often accompanied by pain. As the older population has grown much larger than the past and continues to grow, the issue of euthanasia is being debated within families and in society in general.

Research on euthanasia is unclear, partially due to a lack of clarity on the definition of euthanasia by both researchers and participants. Therefore, it is necessary to clearly define this term. Logue (1991b) explains that there are two forms of euthanasia, active and passive. She explains that "active euthanasia"is a deliberate attempt to end life and it includes suicide or assisted suicide by a friend, family member, or medical person. Active euthanasia also includes the decision of others, such as family members, on the behalf of patients to end their lives (Logue, 1991b). The second type of euthanasia is "passive" which includes the termination or refusal of life sustaining techniques (Logue, 1991b).

Medical practitioners play a large part in the euthanasia debate, due to great strides in life sustaining techniques. Some euthanasia proponents think that the doctors have forgotten how the patient is to live with the pain or a debilitated body, or they wonder

how families are to live with a family member in a coma. Two questions to consider are: First, is life-sustaining technology in the patient's best interest? Second, who should have the control over the decision of whether it is better to die or to live? Freedom of choice is something in which Canadians and Americans pride themselves, but when it comes to euthanasia it is unclear whose choice it should be.

When examining the literature or speaking to the public about the topic of euthanasia for humans, there is controversy over the issue in regard to medical, religious, or legal issues. However, when it comes to the family pet the population as a whole practices euthanasia to end the pet's suffering. The logic behind this practice is that it is the humane thing to do. It is interesting that action is not applied to the human population.

According to some researchers there are drawbacks to legalizing euthanasia. There is concern that abuse will occur to those who are incompetent (Humber, Almeder, & Kasting, 1993). Humber, et al. (1993) believe that patients who are chronically ill may be pressured into requesting euthanasia because they have no health insurance, which is more of a problem in the United States than in Canada. According to Post (1990) if euthanasia is permitted the public may begin to see the elderly as expendable, due to a view that they are financial and emotional burdens. Logue (1991b) believes that euthanasia is a women's issue; women will be encouraged to die because they live longer than men, face terminal illnesses more frequently, and in the United States are more likely to live in poverty with no health insurance thus causing a burden to society.

Euthanasia is a significant issue in the realms of law, medical ethics, religion, and individual rights. As medical technology has extended life expectancy, medical ethical boards are being asked to re-examine prohibitions against physician assisted suicide (Shuman, Fournet, Zelhart, Roland, & Estes , 1992). According to Shuman, et al. (1992), the more experience medical persons have with terminally ill individuals the more likely they will support both active and passive euthanasia.

The general public attitude is shifting toward more positive responses regarding euthanasia (Logue, 1991a). According to Logue (1991a) there has been an increase in acceptability of euthanasia over the years; for example, in 1973 37% thought that a patient could ask the "doctor to put him out of his misery" if he had a terminal illness (p.32). Twelve years later the response to this question increased to 61% (Logue, 1991a). This can be seen in other opinion surveys such as U.S. Gallup Polls (1947, 37% to 1986, 66%), and Canadian General Social Surveys. In 1977 38% of Canadians agreed with an individual with a terminal illness taking his/ her own life, and in 1988 50% agreed (Logue, 1991a).

Statement of Problem

In this thesis I studied changing public opinions toward euthanasia in the United States and Canada, using secondary analysis of public opinion polls . Although it is recognized that public opinions have become more accepting of euthanasia over time in both countries, the relationships between demographic variables and opinions are less known. I analyzed parts of the Canadian Gallup Polls (1984, 1990, 1991), to examine the relationships between demographic factors and euthanasia opinions. A comparison of Canadian and American opinions was made, using the American General Social Survey (1982, 1988, 1991, 1993, 1994). Specifically, opinions toward euthanasia were examined by year, keeping the countries separate through the analysis.

Current knowledge of the euthanasia debate was extended by examining the relationships between attitudes and factors of religion, age, education, gender, income, community size, and marital status. The area of death and dying is a relatively new speciality of the social sciences and may be enhanced by this research. Furthermore, family studies scholars have neglected this topic; however, euthanasia does not just affect individuals but families as well. Theoretical frameworks have not been consistently used to understand and explain euthanasia, and a life course perspective was used in this research.

Terms used in this project are defined below.

Euthanasia. This is has been defined as "good death," and is derived from the Greek

words "eu" meaning "good," and "thanatos" meaning "death" (Gruman, 1982). Euthanasia is currently defined as relieving an individual's suffering by deliberately causing death (Special Senate Committee, 1995).

Active Euthanasia. Logue (1991b) explains that "active euthanasia" includes suicide, or assisted suicide by a friend, family member, or medical person. Active euthanasia also includes the decision of others on the behalf of the patients to end their lives (Logue, 1991a). It is a deliberate ending of life which could include a lethal injection of a harmful substance that results in death.

Passive Euthanasia. Passive euthanasia includes the termination of or refusal to provide life sustaining techniques (Logue, 1991b). This may include removal of oxygen tanks, life support, or chemotherapy. Passive euthanasia removes any treatments that prolong the dying process.

Physician Assisted Suicide. This is when doctors provide patients with the medicine needed to end their own lives (Humber, et al., 1993). This term is often used as a form of active euthanasia.

Death with Dignity. This is defined as the ability to allow a terminally ill individual to choose to avoid or terminate the use of aggressive medical therapies (Menon, 1990).

Informed Consent/ Advance Directive/ Living Will. It is a legal document that a person makes while mentally competent, and it contains the wishes of the person regarding resuscitation orders, use of excessive medications, or other life sustaining techniques

(Special Senate Committee, 1995).

Life Support. This is the use of technology which allows an individual to remain physically alive even though the individual may die without the technology. Life supports include artificial respiration, resuscitation, drugs, surgery, and blood transfusions (Roberts & Gorman, 1996).

Mercy Killing. This occurs when a compassionate individual takes the life of an individual, whether based on the terminally ill patient's wishes or on behalf of a concerned individual (Special Senate Committee, 1995).

Palliative Care/ Hospices. These treatment facilities allow a patient to receive comfort and support in the last days of life, providing patient comfort without use of aggressive therapies (Special Senate Committee, 1995).

Chapter II

Theoretical Perspective

A life course perspective is a useful theoretical approach to study euthanasia. It stresses the importance of context, time, process, and meaning on development of the individual and the families. Specifically, it examines how families change over time. The life course perspective contains five themes, the first of which is time. Three different types of time are addressed (Bengtson & Allen, 1993). Ontogenetic time is concerned with the individual and how events alter behavioral processes. An example of this particular time is when a person experiences a stroke which may result in an unwelcome dependency on a family. A change in thoughts and behaviors towards accepting euthanasia may occur so that the family might not be burdened by the dependent person.

Generational time explores how interactions alter as a result of events or family transitions (Bengtson & Allen, 1993). This may cause some individuals to wish for euthanasia because they do not want to burden their family with a debilitating disease. A person may wish not to be dependent on family members as a result of family discussions on the issue. The dependent person may know that the family does not have the resources or the strength to handle the debilitating disease or the dying family member.

Historical time refers to events that occur in a social context which may affect values of individuals and families (Bengtson & Allen, 1993). For example, the media attention in the United States and Canada to Dr. Kevorkian's assistance with suicide may

affect people's opinions; some individual values may be offended and others' values supported. Dr. Kevorkian is a pathologist who assists individuals with their dying. Death is caused using a machine that he invented, which enables the individual to push a button which starts a sequential release of drugs to initiate death (Roberts & Gorman, 1996). Many individuals see Dr. Kevorkian as a hero, as someone who helped when no one else will. This may result in values changing to accept euthanasia because the individual or family may see the reasoning behind Dr. Kevorkian. Other individuals may be offended because some feel that God is the only one who can decide who should die.

A second theme, context, such as social construction of meaning and cultural attitudes is essential when examining development (Bengtson & Allen, 1993). As a result of changes in technology, specifically the medical field, it is possible to extend life. Doctors now have the technology to apply techniques which patients might not wish. Techniques can keep a person breathing but the brain not fully functioning.

Third, change occurs over time to individuals and families. The transition to old age takes time and may lead some individuals to contemplate their deaths or onset of debilitating diseases. Preparation for a debilitating disease may lead to the creation of an advance health care directive. This may result in thoughts about euthanasia as a possible course of action, especially if there is no cure likely with high levels of pain. Therefore, analysis of age cohorts is important to euthanasia because there tends to be a higher level of need or likelihood of experiencing debilitating diseases or unwanted life-sustaining

techniques among older persons.

Fourth is heterogeneity, which means that trends are examined but also diverse patterns are explored (Bengtson & Allen, 1993). When examining the trends it is apparent that there is more general acceptance towards euthanasia now than in the past. However, on an individual level, there are many different people with divergent views on euthanasia. Some believe that euthanasia should only be allowed with the doctor's approval while others believe that euthanasia should not be allowed at all. Over time many individuals may change their opinions based on development of new or changing ideas and life experiences.

Finally, the life course perspective is multidisciplinary, borrowing from other disciplines such as biology, psychology, and religion to explain trends over time (Bengtson & Allen, 1993). When examining health issues using the life course perspective, it becomes apparent that other disciplines come into play. A biological deterioration in health may occur in old age; therefore, many thoughts may arise regarding death or euthanasia. In addition, psychology or psychiatry may be used to examine motives for euthanasia. For example, in some cases as individuals become older depression occurs because the person is unable to complete tasks as he/ she once did when younger. Furthermore, religion is another discipline which may help explain attitudes toward euthanasia. For example, many individuals feel that God is the only decider for who shall die.

Chapter III

Review of Literature

As will be shown below, there is a trend toward increasing acceptance of euthanasia as a choice in society as a whole and within the older population in particular. One indicator is shown by the increased use of advanced directives or living wills (Law Reform Commission of Canada, 1982). A number of factors affect euthanasia opinions, including people's age, gender, and health concerns (Sonnenblick, Friedlander, & Steinberg, 1993). It is essential to examine each of these, as well as the medical, legal, religious perspectives.

Age and Religion Affecting Opinions

Leinbach (1993) found that 60% of persons between the ages of forty-five and eighty-five years support euthanasia decisions, and it was found that the percentage of acceptance was lowest for the youngest group and highest for the oldest group. According to Seidlitz, Duberstein, Cox, and Conwell (1995) individuals preferences varied according to the strength of religion. If religion was a large part of peoples' lives and they attended church quite regularly, acceptance of euthanasia was less likely, regardless of age.

Gender Affecting Opinions

Logue (1991a) found that if individuals had recently moved into a long term facility or into an adult child's home and were men they were more likely than women to

believe in euthanasia. This may be due to gender biased differences in socialization patterns, education, or religion (Ward, 1980). Women are socialized to accept what happens to them and men are socialized to act in undesirable situations (Logue, 1991a). In addition, historically, women complete lower levels of education and are more religious than men (Logue, 1991a).

Health Concerns Affecting Opinions

Logue (1991b) expressed the view that as more people in a society accept euthanasia as a choice, the individuals within this society will begin to accept euthanasia for themselves. Euthanasia tends to be a controversial topic; as an increasing number of individuals become more vocal about their individual beliefs regarding euthanasia, the issue will be less controversial. The result is that there is a higher percentage of acceptance of euthanasia across time (Logue, 1991b).

Logue (1991b) explores the issue of having control over one's own body, including control over one's death, and sees this as an essential argument in the debate. Having control over one's health is as important as having control over one's death, according to this view.

Another issue in the euthanasia debate is people's concern about being dependent, experiencing dementia, and being in pain (Prado, 1990). Euthanasia appears to be a way of escaping all of the negative health aspects of old age that are problematic. Furthermore, the individuals are also concerned about a reduction in the quality of life if life sustaining

techniques are used (Schonwetter, Walker, Kramer, & Robinson, 1994). If physicians do not prepare patients for the debilitating consequences of life sustaining treatments they are often left feeling much worse than if they had not received treatment (Beauchamp, & Veatch, 1996).

On the opposing side there is a concern that permitting euthanasia to take place will allow society to kill disabled individuals against their will, specifically, those with Lou Gehrig's disease (Amyotrophic Lateral Sclerosis), Alzheimer's, or multiple sclerosis (Ontario Consultants on Religious Tolerance, 1995).

Medical Perspective, with Comparisons between the United States and Canada

It is essential to examine how medical care affects the opinions towards euthanasia. A power difference exists between physician and patient. Doctors and nurses have knowledge of medical procedures which not only prolong life, but they can also end the patient's pain and suffering. The medical profession comes from a perspective in which practitioners are not only ethically bound to provide comfort when dying, but also they may be held criminally negligent if they assist with death. According to the Research Branch of the Library of Parliament (1995) under Canadian legislation the actions of doctors can be prosecuted.

Three points in the Canadian Medical Association's Code of Ethics apply to euthanasia. First, physicians must inform their patients when their biases may detract from recommending certain types of therapies (Department of Bioethics, 1992). This may

cause a physician to be unable to suggest a certain form of therapy which may assist in alleviating some pain and discomfort for the patient.

Second, Canadian Medical Ethics permit death to occur without pain and with dignity (Department of Bioethics, 1992). This means that a physician should apply techniques or medications which assist patient comfort.

Third, physicians may provide life support to the body when the brain is dead, but there is no need to apply any "unusual or heroic measures" to prolong life (Department of Bioethics, 1992). The Canadian Medical Association officially stated that it does not support euthanasia even though this is not explicitly stated in their code of ethics (Department of Bioethics, 1992).

The American Medical Association's Code of Ethics states that the physician's role is "healer" and euthanasia and assisted suicide go against the physician's role (American Medical Association, 1996). Hadjistauropoulos (1996) found that four points of the American code of medical ethics applied to euthanasia; it is the physician's responsibility to be honest with patients, respect the law, guard the rights of patients within the limits of the law, and to take part in activities that assist in a community of choices. None of these points explicitly prohibit the physicians from assisting with death; however, Hadjistauropoulos (1996) says that it is implied by stressing that a physician must be lawful.

Personal beliefs of medical practitioners play a large part regarding cessation of

treatment or even application of aggressive therapies (Research Branch of the Library of Parliament, 1995). If the physician believes that the treatment will be unsuccessful or if there is no hope for survival, either may influence the physician's decision to forego treatment (Research Branch of the Library of Parliament, 1995).

A Michigan pathologist, Dr. Kevorkian, has increased the media and public attention to the topic of euthanasia. Dr. Kevorkian has assisted individuals with their suicides. He built a machine to help with the suicides, called a "mercitron"(Roberts & Gorman, 1996). An IV line is started and then the machine injects a saline solution (Roberts & Gorman, 1996). When the individual is ready, he/she pushes a button to initiate a sleep-inducing drug and then potassium chloride, which stops the heart (Roberts & Gorman, 1996). Dr. Kevorkian and the publicity about him and his suicide machine have brought a certain twist to the issue (Dickinson, Leming & Mermann, 1994). Dr. Kevorkian has publicized his personal views on euthanasia or physician assisted suicide, which is rare in the medical field.

As most physicians argue against euthanasia or physician assisted suicide due to their ethical position and their code of ethics, little is known about their personal views and their feelings about the issue without the medical ethics frame of mind (Dickinson, et al., 1994). For example, one physician explained his relationship with one of his patients whom he had known over many years; he appeared to understand the patient's point of view about euthanasia (Arras & Rhoden, 1989). It was interesting because most

physicians do not express their personal understanding of euthanasia as it contradicts the medical ethics. As this physician understood how his patient felt and understood her background, he expressed compassion as he assisted her death (Arras & Rhoden, 1989). It was intriguing because the physician went against medical ethics codes and treated his patient with the treatment that the patient requested.

According to the Research Branch of the Library of Parliament (1995) more than half of the respondents of a 1991 survey of Alberta doctors favored legislative changes which would permit requested active euthanasia. This point demonstrates that physicians have beliefs which conflict with their code of ethics.

A main opposing view to euthanasia is that physicians take an oath to save lives. Some doctors are therefore uncomfortable helping people end their lives (Ontario Consultants on Religious Tolerance, 1995).

Death with dignity is a current concern of patients and their families. To each person and each family this term (death with dignity) means something different, but basically it is allowing the patient to have control over his/ her death. This means a person may die without pain, without being dependent, or without dementia (Prado, 1990). Furthermore, death with dignity enables patients to play a part in the decision making process of their deaths and dying with respect. The desire to die with dignity is usually expressed verbally to family and physicians, or in the form of an advance directive or living will.

The advanced directive allows an individual to make his or her choices of treatment clear by explicitly explaining it in a formal document (Special Senate Committee, 1995). This document is produced by a competent person concerning decisions about health care, to be acted upon when the person becomes unable to express his or her wishes. Unfortunately, only the Canadian provinces of Quebec, Ontario, Manitoba, and Nova Scotia have passed legislation allowing advance directives (Special Senate Comittee, 1995).

There are several points against euthanasia. Permitting physicians to assist with death can give them too much power. Information doctors give patients about their diagnosis may be mistaken, or doctors may be unaware of new treatments (Christian Medical Fellowship, 1997). Furthermore, doctors' own personal beliefs may get in the way of explaining a patient's options (Christian Medical Fellowship, 1997). Euthanasia is not always the only course of action; many patients are not given all their options on alternative solutions or treatments. Those who experience a terminal illness are fragile; they experience many emotions such as, fear, anxiety, and depression which may affect their decision to accept euthanasia (Christian Medical Fellowship, 1997).

Health care appears to be a different issue in the United States than in Canada for physicians and their patients. In the United States physicians base decisions of who will receive certain treatments on who can afford it (Jecker, 1994). Medical care has increased in costs and limitation of resources has been the result (Lo & Jonsen, 1980). Medical

costs are more expensive during the last days of life of an individual who is terminally ill than in other stages of life (Jecker, 1994). Sometimes if a patient does not have appropriate medical insurance expensive treatments are not offered to the patient, according to Jecker (1994). Health insurance in the United States is based on occupation. It is the employee's responsibility to pay for medical insurance, and private medical insurance without employer group plans is very expensive (Jecker, 1994). It is possible, given high costs of medical treatments, that Americans may be more accepting of euthanasia than Canadians.

In Canada, the health care system is supposed to follow five principles, "portability, accessibility, public administration, comprehensiveness, and universality" (Gray, 1996). Canadian health care is a public system funded by governments, whereas American health care is a market driven system (Gray, 1996). According to Gray (1996), public funds play a larger role in Canadian health care than in the American health care system, therefore, it appears that the health care system may influence Americans to favor euthanasia decisions more frequently than Canadians.

Legal Perspective

Legally, active euthanasia is a crime and defined as murder. According to the Special Senate Committee (1995), anyone practicing active euthanasia can be charged with "offences of murder, manslaughter, or criminal negligence causing death" (p. 52). However, in current law cases it is evident that the judge and jury have based their

decision on compassion, resulting in lenient sentencing (Smith, Alter, & Harder, 1995). Over the years a few court cases have occurred, such as Karen Quinlan, Sue Rodriguez, and Nancy B., bringing euthanasia into the public arena. Karen Quinlan, suffering from permanent damage to the brain and in an irreversible coma due to a drug and alcohol accident, is an icon in the American justice system on the issue of euthanasia. In 1976 the New Jersey Supreme Court ruled that the respirator could be removed, which was a decision that neither the attending physician nor the hospital would not make (Smith, et al., 1995). This case was essential in re-introducing the quality of life argument, as the courts examined the benefits and costs of continued treatment to Karen Quinlan (Smith, et al., 1995).

In Canada, in 1992, two court cases were underway fighting for the rights of two women. The first was Nancy B., who was suffering from an incurable disease and wanted her respirator disconnected (Smith, et al., 1995). The court ruled in Nancy B.'s favor, reasoning that her "disease should take its natural course" based on the Canadian Charter of Rights and Freedoms (Smith, et al., 1995, p.7). Sue Rodriguez had Amyotrophic Lateral Sclerosis and fought to receive the court's permission to have assistance with her death. Although the courts ruled against her, Sue Rodriguez was helped to commit suicide by a physician (Smith, et al., 1995).

These court rulings show that the courts favor individual rights. However, according to the President's Law Commission (1983), a physician is obligated to provide

a patient with all the treatment options, but it is the patient's decision to accept or reject treatment.

According to the Law Reform Commission of Canada (1982) "instances in which the law fails to penalize actions intended to terminate human life are rare" (p. 3). The courts appear to be showing compassion towards the patient especially when it involves medical treatment. Areen, King, Goldberg, and Capron (1984) explain that the courts have tried to protect human rights by keeping some essential points in mind, preserving life, preventing suicide, protecting third parties, and maintaining the ethical point of view of physicians. However, the court decisions are still based on the judge's view of quality of life (Menon, 1990).

Mercy killing is a concern when examining euthanasia cases. It is important for the public to know the motives behind those who assist with death. Currently, mercy killing is a serious crime. When the mercy killer is brought into the criminal justice system his/ her motives are not examined; however, if motives were examined, it may lead to a more lenient sentence (Wickett, 1988).

Physicians make end of life decisions every day. These are handed to the courts when there is a question by a medical review board or the individual whose life is in question. Courts are involved when it is unclear as to what treatment a patient wants due to the inability of the patient to communicate his/ her wish.

Euthanasia may need a separate law because guidelines followed by the courts

appear to be using laws on suicide and individual rights. Formulating laws or guidelines specifically for euthanasia should not exclude quality of life values, as they shape both the court's and individual's decisions on the issue of euthanasia (Law Reform Commission of Canada, 1982). Individuals believe it is essential to have their autonomy regarding their deaths, which is provided through their "free choice" (Menon, 1990).

Oregon has been dealing with the issue of legalizing euthanasia under the "Death with Dignity Act" (Ontario Consultants on Religious Tolerance, 1995). The state has guidelines to determine acceptability of euthanasia such as: the person must be terminally ill, must request assistance with death three times (two orally and one written), must convince two physicians that he/she is sincere and is not depressed, must be informed of alternative care, and must wait for 15 days (Ontario Consultants on Religious Tolerance, 1995). The only way a person could receive assistance is with the method of an oral medication sufficient to result in death (Ontario Consultants on Religious Tolerance, 1995). New York, Florida, and Washington State express that physician assisted suicide is a criminal offence and will not change the law (Ontario Consultants on Religious Tolerance, 1995).

In Canada, Maurice Genereux was the "first Canadian physician to be convicted of assisted suicide" in December 1997 in Toronto (International Anti-Euthanasia Task Force, 1998). He prescribed two HIV patients lethal doses of barbiturates because Genereux believed they had no hope of surviving (International Anti-Euthanasia Task

Force, 1998). Another Canadian physician, Nancy Morrison, in 1996 had her charges of manslaughter dismissed in Nova Scotia (International Anti-Euthanasia Task Force, 1998). Anti-euthanasia lobbyists raise an important point: If patients are told about all options of care euthanasia would not be requested. Therefore, the decisions to make tougher laws or laws dealing specifically with euthanasia are not necessary (International Anti-Euthanasia Task Force, 1998).

Religious Perspectives

Many of the great philosophers of the past expressed their views of euthanasia. Between 500 to 200 B.C. it was thought that euthanasia was acceptable, provided those who wished to practice euthanasia received permission from an official (Roberts & Gorman, 1996). Plato believed that it was acceptable to practice euthanasia if the individuals were incurably ill and it was authorized by the state (Roberts & Gorman, 1996).

With the rise of Christianity by 330 A.D. it was forbidden to practice euthanasia (Roberts & Gorman, 1996). The Christian view was that God determined whether individuals should live or die (Roberts & Gorman, 1996). From 354 to 430 A.D., St. Augustine condemned the use of euthanasia as it went against church policies (Larue, 1985). During the Middle Ages it was considered a sin to practice euthanasia, and during the Renaissance era, Protestants and Catholics condemned the use of euthanasia and through the courts it became a law that euthanasia was a crime (Roberts & Gorman,

1996).

Religion is a specific system of belief or religious affiliation, and religiosity describes individuals who are "devout and pious, concerned with religion" (Webster's New World Dictionary, 1984). For this study religious affiliation was examined.

Roman Catholic Perspective.

Officials of the Roman Catholic Church have been the most vocal against euthanasia. Church doctrine suggests that God is the decider of who shall live and who shall die, and an individual does not have the right or the power to make these decisions. Catholics are taught to believe that God created all life and only God can control it. Furthermore, Earth is a stepping stone in God's plan, and suffering on earth provides "man" with the feeling of humility which purifies him/her for heaven. Therefore, the Catholic Church officials have actively condemned euthanasia.

The Catholic Church doctrine prohibits any use of active euthanasia, however, there is a possibility to practice some leniency: If ending a person's suffering is the "lesser of two evils" and there is no other choice then the church officials will condone the decision (Larue, 1985). According to Coleman (1985), Pope Pius XII declared that individuals had the right to die when medical intervention has become extreme and a natural death has been prolonged due to technological advances.

Greek and Russian Orthodox Perspective.

Members of the Greek and Russian Orthodox Church disagree with active

euthanasia, but they believe that life support is not essential in God's plan (Larue, 1985). Suffering is seen as repentance for our sins and "salvation for our souls," but God did not intend for outside interference or artificial life prolongation (Larue, 1985).

Jewish Perspective.

Jewish individuals, as well as those with no affiliation, were more likely to support euthanasia than others (Ostheimer & Moore, 1981). According to Larue (1985), Jews condemn the use of active euthanasia; however, they do practice leniency in special cases, especially regarding passive euthanasia. As with the Catholic perspective passive euthanasia is the better of the "two evils."

Lutheran and United Church Perspective.

The Lutheran Church condemns euthanasia as an unacceptable practice. It views life as God's gift (Larue, 1985). The United Church, on the other hand, disapproves of active euthanasia, but provides leniency towards passive euthanasia (Larue, 1985). It is believed that it is God's will to continue physical existence, and life is seen as precious and essential to God's plan (Larue, 1985).

Religious Affiliation and Attendance.

Overall, it appears that religious affiliation is associated with euthanasia beliefs. It is generally unacceptable to practice active euthanasia, but leniency is practiced towards passive euthanasia, especially in extreme cases, by some churches. Ostheimer (1980) found that individuals who have more liberal religious views are more likely to be in

favor of euthanasia. In addition, Singh (1979) found that regular church attendance along with strong participation were inversely related to acceptance of euthanasia.

In summary, this review of literature represents the euthanasia debate among the medical, legal, and religious areas. Each group brings to the euthanasia issue their own divergent ethical standards and opinions. Unfortunately, there has been no real consistency to develop unified proposals or guidelines regarding euthanasia.

Euthanasia Opinion Changes over Time

Through examining public opinions there appears to be an acceptance of euthanasia. Gallup Polls reported an increase in acceptance towards euthanasia from 37% in 1947 to 78% in 1990 (Logue, 1991b). The media reflects public opinion. A number of articles in the popular press have examined euthanasia. For example, media coverage of Dr. Kevorkian's 38 assisted suicides from 1991 to 1996 has been extensive (Roberts & Gorman, 1996). Although this topic has come under media scrutiny as a result of high profile cases, there has been no real inquiry into the correlates of the Canadian and American public opinions toward euthanasia. Multivariate techniques can assist understanding of the relative influence of several variables on attitude. In addition, when examining the research there appears to be a lack of theoretical perspectives guiding the research of euthanasia. Using a life course perspective in this research can also clarify our understanding.

Chapter IV

Methodology

Research Design

This study was a secondary analysis of the American General Social Survey and the Canadian Gallup Poll. Both are national opinion polls, each of which had a question on euthanasia. These questions form the dependent variable in this research. They were worded as follows:

"When a person has an incurable disease that causes great suffering, do you, or do you not think that competent doctors should be allowed by law to end the patient's life through mercy killing, if the patient has made a formal request in writing?" (Canadian Gallup Poll). Possible responses included, "yes (should)," "no (should not)," "doesn't know," or "not stated."

"When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?" (American General Social Survey). Possible responses included, "yes," "no," "don't know," or "no answer."

Samples

The data for this study were derived from the 1984, 1990, 1991 Canadian Gallup Poll, conducted annually by the Canadian Institute of Public Opinion at Carleton University. Other data for this study were derived from the 1982, 1988, 1991, 1993, 1994

General Social Surveys of the United States, conducted annually by the National Opinion Research Center at the University of Chicago. The surveys were conducted using a random sample each year of households in Canada and United States respectively.

The Canadian Gallup Poll interviewed 4,023 respondents, who spoke English or French. These telephone interviews covered a variety of variables, such as politics and social issues. The subjects were 18 years of age and older, who did not live in an institution. Everyone interviewed was asked the euthanasia question.

The American General Social Survey's respondents were English speaking, 18 years of age or older, and not living in an institution within the United States. These telephone interviews lasted approximately 1 ½ hour each. Over the years chosen for this study 35, 284 respondents were interviewed on 2,700 variables ranging from family and the life cycle to politics. Not all variables were asked of every individual. The aim of the General Social Survey was to ask questions about American public opinion. The years which were examined were all overseen by directors James A. Davis and Tom W. Smith at the University of Chicago.

Variables and Hypotheses

The variables to be related to euthanasia within the American General Social Survey and the Canadian Gallup Poll are age of respondent, gender, income, education, religious affiliation, community size, and marital status. These variables selected for analysis are representative of the theoretical perspective or have been found to be

predictive of euthanasia opinions in previous research. Furthermore, the United States and Canada were statistically compared on these variables to see if there were any country differences.

Age of Respondent.

This variable was chosen because there have been several research articles outlining the importance of age in predicting opinions toward euthanasia. Leinbach (1993) found that majority of individuals at the older ages (60%) supported euthanasia and that there was the highest percentage of acceptance within the oldest age group. The life course perspective states that individuals change over time, specifically preparing for death or painful diseases (Bengtson & Allen, 1993). Since older individuals, as a group, are experiencing deaths of cohort members, together with greater likelihood of their own deaths, they will support euthanasia more than younger people. Ward (1980) found that the elderly had more acceptance of death than the younger generation. Older individuals are defined in this study as 50 years and over, because this was the way the Canadian data were categorized. The same definition of the elderly (50 years of age and older) was carried over to the American General Social Survey for comparisons.

H1. It is hypothesized that older individuals will support euthanasia more than younger ones over time.

Gender.

There has been some controversy over gender influencing euthanasia opinions.

Ward (1980) found that women were less likely to support euthanasia. However, Logue (1991a) found that slightly more men then women support euthanasia decisions. Logue (1991a) also goes on to explain that this is a woman's issue as women live longer than men; therefore, they experience more long-term diseases and more dementia, which may lead to the use of euthanasia. According to the life course perspective many individuals will change their opinions over time as a result of experience (Bengtson & Allen, 1993) and since there are more old women alive who may influence one another it is expected that women will be more supportive of euthanasia than men.

H2. It is hypothesized that there will be greater support by women than men for euthanasia over time.

Income.

Previous research has found that the lower someone's income is the more accepting of euthanasia he or she will be (Ward, 1980). Ward (1980), who is an American researcher, found that persons with lower incomes may feel a sense of burden or shame in regards to use of the medical field, particularly, if they cannot afford certain techniques. As individuals move through the life cycle they may be faced with medical technology to extend their body's life but unable to afford the new technology (Bengtson & Allen, 1993). In regards to health care, the final days of life for a terminally ill individual are the most expensive. According to Jecker (1994), American physicians base decisions of who will receive certain treatments on who can afford it. Euthanasia may

stop a lengthy treatment thus cutting health care costs. Persons with lower incomes do not receive the same treatment as individuals with higher incomes.This may be due to individuals not able to afford a phone to call for help, or prejudices occurring toward individuals with lower incomes. This treatment or lack of treatment will affect views of individuals with lower incomes.

H3. It is hypothesized that individuals with lower incomes will be more accepting of euthanasia than people with higher incomes over time.

H4. In addition, with the privately funded U. S. system of health care, it is hypothesized that Americans will be more accepting of euthanasia than Canadians over time.

Education.

Research indicates that the higher someone's educational attainment is the more accepting of euthanasia he or she will be (Weiss, 1996). A person with more education may better understand the debate of euthanasia. Over time an individual's knowledge increases, suggesting as people gain understanding through the life course they will be more accepting of euthanasia.

H5. It is hypothesized that persons with more years of education will be more accepting of euthanasia than persons with fewer years of education over time.

Religious Affiliation.

Through examining the research on religion it was found that both Protestants and Catholics hold strong views against euthanasia; therefore, the persons of these faiths, following their church doctrine, will be more inclined to disagree with euthanasia. The Jewish community is more likely to be in favor of euthanasia than other religions (Ostheimer & Moore, 1981).

H6. It is hypothesized that Jewish individuals will be more favorable to euthanasia than persons of other religions over time.

Community Size.

According to Menon (1990) those from smaller communities have more social integration resulting in a lack of acceptance of euthanasia. This is because smaller communities are lacking many resources which provide education on euthanasia and opportunities for medical interventions; therefore, small communities rely on rumors, churches, and family beliefs held for generations about euthanasia. Larger communities change and develop over time faster than small communities. The result of change and development in larger communities is more access to the ever-changing technology and development of new ideas through social institutions.

H7. It is hypothesized that individuals from larger communities will be more accepting of euthanasia than people from small communities or rural areas over time.

Marital Status.

According to Menon (1990) those who are married have a higher acceptance of euthanasia. This may be a result of individuals believing that euthanasia may be a way to relieve any pain that a disabling illness that he or she experiences may cause other family members. The life course perspective examines ontogenetic time, or how events alter the behavioral processes (Bengtson & Allen, 1993). Married individuals are expected to support euthanasia as they may wish not to be a burden to their spouses.

H8. It is hypothesized that married individuals will be more accepting of euthanasia than people of other marital statuses over time.

Multivariate Expectations.

Previous research has largely been bivariate, and there is a need for determining the relative effect of the variables through multivariate techniques. It is expected that religious affiliation will have the strongest effect on euthanasia opinions, relative to age, marital status and education. According to Weiss (1996) and Menon (1990) religious affiliation is the strongest predictor of euthanasia acceptance. It is further expected that age will have a stronger effect on euthanasia opinions, when compared to gender, community size and income. Ward (1980) found that age is a strong predictor of acceptance of euthanasia, a finding in line with a life course theoretical perspective.

H9. When examining the predictors of euthanasia acceptance it is hypothesized that religious affiliation will be the strongest predictor, followed by age over time.

Chapter V

Results

Sample Descriptions and Country Comparisons

The samples from the two countries were similar in some respects but different in others. As can be seen in Appendix A the Canadian samples were more likely to be 30- 49 years in age, male, have incomes of $20,000 and over, have an education of grade 9 and over, be Roman Catholic, live in communities over 500,000, and be married. The American samples, as shown in Appendix B, tended to be middle aged (ages 30-49), female, earn $25,000 or more, have attained an education of grade 9 and over, be Protestant, live in communities of 1,000 to 10,000, and be married. The samples from the two countries are similar in income and marital status; they differ in religion, size of community, and gender.

Hypothesis Testing

The first hypothesis, that older individuals would support euthanasia more than younger ones, was not supported by the Canadian Gallup poll (see Table 1) or the American General Social Survey (see Table 2). Reading down columns of Table 1, results showed there was more acceptance of euthanasia at younger ages. These results were unlikely to be due to chance, as shown by the X^2 values, although the strength of association was weak, as shown by λ values. To analyze results over time, X^2 analysis was performed on rows of Table 1. Results showed the percentage of euthanasia acceptance

among Canadian 18-29 year olds increased from 72.4% in 1984 to 78.2% in 1991 ($X^2 = 2.534$, $p<.002$). Among Canadians ages 30-49 years the percentage of euthanasia acceptance has increased from 68.6% in 1984 to 78.7% in 1991 ($X^2 = 2.616$, $p<.001$). The percentage of euthanasia acceptance among Canadians ages 50 years and over increased from 56.2% in 1984 to 66.3% in 1991 ($X^2 = 2.131$, NS). Thus the significant increases in acceptance were at younger ages (See Table 1).

Turning to results from the United States in regard to Hypothesis 1, reading down columns in Table 2, significant differences among age groups during each period of data collection occurred, again in the opposite direction predicted by Hypothesis 1. Older people in the United States, like those in Canada, were less supportive of euthanasia than their younger counterparts. The percentage of euthanasia acceptance among Americans ages 18-29 years increased from 67.3% in 1982 to 76.3% in 1994; among Americans ages 30-49 years, acceptance increased from 62.2% in 1982 to 75.5% in 1994; and among Americans ages 50 years and over increased support from 48.5% in 1982 to 63.7% in 1994. Calculation across rows of Table 2 yielded X^2 values that were not statistically significant. In conclusion Hypothesis 1 was not supported within age groups for either country and across time only for Canada.

Table 1

Percentage of Respondents in Canadian Gallup Poll Agreeing that Doctors Can End Life, by Age and Year

Age	1984 (n)	1990 (n)	1991 (n)	X^2	p
18- 29	72.4(186)	80.6 (174)	78.2 (172)	2.534	‹.002
30- 49	68.6(277)	85.1 (399)	78.7 (337)	2.616	‹ .001
50 and over	56.2(212)	68.6 (251)	66.3 (248)	2.131	NS
X^2	31.167	37.791	26.328		
p	‹ .002	‹ .001	‹ .001		
λ	.000	.005	.000		

Table 2

Percentage of Respondents in American General Social Survey Agreeing that Doctors can End Life, by Age and Year[a]

Age(years)	1982(n)	1988(n)	1991(n)	1993(n)	1994(n)	X^2	p
18 - 29	67.3(317)	76.1(178)	80.9(157)	79.3(161)	76.3(254)	5.135	NS
30 - 49	62.2(375)	71.1(263)	77.1(334)	72.3(319)	75.5(642)	6.375	NS
50 & over	48.5(334)	62.5(207)	65.7(228)	57.6(216)	63.7(438)	5.152	NS
X^2	46.768	12.706	19.366	34.515	31.070		
p	‹ .001	‹ .002	‹ .001	‹ .001	‹ .001		
λ	.000	.000	.000	.000	.000		

Note.[a] Excluded from these data are the 21 who did not answer the question. In 1982, 9 individuals did not answer; in 1988, 1;1991, 1; in 1993, 6; and in 1994, 4.

The second hypothesis, that there would be greater support by women than by men for euthanasia, was not supported. Reading down columns of Table 3 no significant gender differences were shown in Canada; reading down columns of Table 4 significant American differences were shown in 1982 and 1994 but not in the other years.

To assess time changes row chi square values were calculated for Canada (Table 3) and for the United States (Table 4). Statistically significant increases in support occurred from 1984 to 1991 in Canada and from 1982 to 1994 in the United States, but

those differences did not occur in a steadily increasing fashion from one year to the next. In conclusion Hypothesis 2 was not supported for gender differences but both men and women in Canada and the United States increased their support for euthanasia over time.

Table 3

Percentage of Respondents in Canadian Gallup Poll Agreeing that Doctors can End Life, by Gender and Year

Gender	1984 (n)	1990 (n)	1991(n)	X^2	p
Male	65.6 (347)	79.6 (418)	74.3 (382)	59.805	‹.001
Female	63.9 (333)	77.2 (406)	73.8 (375)	71.412	‹.001
X^2	2.150	3.887	1.005		
p	NS	NS	NS		

Table 4

Percentage of Respondents in American General Social Survey Agreeing that Doctors can End Life, by Gender and Year

Gender	1982 (n)	1988(n)	1991(n)	1993(n)	1994(n)	X^2	p
Male	62.5(464)	73.8(307)	77.5(313)	71.0(325)	76.1(587)	45.639	‹.001
Female	55.0(562)	65.7(341)	71.2(406)	66.1(371)	67.9(747)	57.568	‹.001
X^2	9.908	7.113	4.774	2.716	14.988		
p	‹.002	NS	NS	NS	‹ .001		

The third hypothesis, that individuals with lower incomes would be more accepting of euthanasia than individuals with higher incomes was not supported. Chi square values for columns in Tables 5 and 6 were not statistically significant except for the American General Social Survey sample in 1982. In that case results were not in the expected direction.

Turning to time changes in support of euthanasia by income level, and reading across rows of Table 5, Canadian results showed a significant increase in support from 1984 to 1991 at income levels above $10,000 but no change in support for individuals with low income. In the United States no significant change occurred over time. (See row X^2 results in Table 6.) There appeared to be no real trend between income and euthanasia acceptance over time. The income groupings were chosen because the Canadian Gallup

Poll and the American General Social Survey had already existing income groupings.

Table 5

Percentage of Respondents in Canadian Gallup Poll Agreeing that Doctors can End Life, by Income and Year

Income	1984 (n)	1990 (n)	1991 (n)	X^2	p
Under $10,000	63.0 (80)	74.5(35)	71.1(27)	18.865	NS
$10- $14,999	58.8 (57)	65.0(39)	75.0(57)	33.378	‹.001
$15- $19,999	56.3 (45)	75.8(50)	71.4(55)	21.504	‹.001
$20,000 & over	66.8 (498)	82.2 (582)	74.4(618)	30.016	‹.002
X^2	14.074	34.616	2.082		
p	NS	NS	NS		

Table 6

Percentage of Respondents in American General Social Survey Agreeing that Doctors can End Life, by Income and Year[a]

Income	1982(n)	1988(n)	1991(n)	1993(n)	1994(n)	X^2	p
› $10,000	59.3(267)	66.9(117)	72.5(121)	74.3(113)	70.8(192)	7.324	NS
$10- $14,999	61.5 (139)	74.2(69)	78.8 (63)	62.7(47)	75.2(121)	14.953	NS
$15- $24,999	71.6(197)	78.4(116)	77.1(121)	72.2(114)	73.1(226)	2.736	NS
$25,000 ‹	67.7(90)	72.4(134)	80.7(163)	73.0(195)	80.4(390)	15.318	NS
X^2	36.214	19.755	11.160	11.989	12.428		
p	‹.001	NS	NS	NS	NS		
λ	.024	.000	.000	.000	.000		

Note.[a] Excluded from these data are 2189 subjects who did not answer the question. In 1982, 631 subjects did not answer the question; in 1988, 308; in 1991, 348; in 1993, 333; and in 1994, 569.

The fourth hypothesis, that Americans would be more accepting of euthanasia than Canadians was difficult to test since comparable years of data collection were not available except for 1991. The percentage of euthanasia acceptance among Canadians increased from 72% in 1984 to 81% in 1991, a significant increase across rows of Table 7. The percentage of euthanasia acceptance among Americans increased from 58% in 1982 to 71% in 1994, significant across rows of Table 8. By examining euthanasia acceptance percentages in 1991, the only year of data collection in common there was

more acceptance by Canadians (81%) than Americans (73.8%). The chi square for the 2 x 2 analysis of the combined data sets is 2.000, p= .157. For 1991 it is concluded that the difference between the Canadian data and the American data is not statistically significant.

Table 7

Percentage of Respondents in Canadian Gallup Poll Agreeing that Doctors can End Life, by Year

Response	Year				
	1984 (n)	1990 (n)	1991 (n)	X^2	p
Yes (should)	72.2 (680)	84.9 (824)	81.0 (757)	130.88	‹.001
No (should not)	27.8 (262)	15.0 (146)	19.0(177)		

Table 8

Percentage of Respondents in American General Social Survey Agreeing that Doctors can End Life, by Year

Response	Year						
	1982 (n)	1988(n)	1991(n)	1993(n)	1994(n)	X^2	p
Yes	58.2(1026)	69.3(648)	73.8(719)	68.3(696)	71.3(1334)	101.11	‹.001
No	41.8(737)	30.7(287)	26.2(255)	31.7 (323)	28.7(537)		

The fifth hypothesis, that persons with more years of education would be more

accepting of euthanasia than persons with fewer years of education was supported by the American data but not by the Canadian, using chi square calculations by educational group (education as a discontinuous variable due to existing groupings in the data set). Reading down columns in Table 9 Canadian results were not significant; respondents in the United States, shown down columns of Table 10, were less likely to support euthanasia if they were educated to Grade 8 level or less than if they achieved secondary or post secondary education. These results held in all 5 years studied but associations were weak, as shown by lambda values on Table 10.

Table 9

Percentage of Respondents in Canadian Gallup Poll Agreeing Doctors can End Life, by Education and Year

Education	1984(n)	1990(n)	1991(n)	X^2	p
Public Grades 1-8	57.9(117)	72.0(85)	63.3(76)	26.813	‹.001
Secondary School 9-13	66.0 (316)	82.3(382)	75.3 (314)	60.662	‹.001
Post Secondary	76.2(242)	76.2(353)	75.7(364)	28.535	‹.001
X^2	17.099	24.078	19.013		
p	.313	.239	.213		
λ	.000	.000	.004		

Looking across rows of Tables 9 and 10 to assess time changes, in 1984, 57.9% of

Canadians who attained Grade 8 or less education approved of euthanasia, and the percentage increased significantly to 63.3% in 1991. For Canadians in grades 9 to 13, a significant increase from 66% in 1984 to 75.3% in 1991 occurred; a significant decrease occurred among Canadians with post secondary education (from 76.2% in 1984 to 75.7% in 1991). Time changes were nonsignificant for every educational group in the United States, as shown across rows in Table 10.

In summary Hypothesis 5 was partially supported. Americans with more education supported euthanasia, while Canadian differences were insignificant. Over time Canadians at lower education levels supported euthanasia more while the opposite was true for Canadians with post secondary education. No time changes within education levels were observed for Americans.

Table 10

Percentage of Respondents in American General Social Survey Agreeing that Doctors can End Life, by Education and Year[a]

Education	1982(n)	1988(n)	1991(n)	1993(n)	1994(n)	X^2	p
Public Grades 1-8	39.2(98)	49.0(48)	52.6(41)	55.1(49)	57.1(68)	3.785	NS
Secondary School 9-12	68.0(98)	71.5(362)	75.9(394)	66.3(340)	70.2(684)	14.707	NS
Post Secondary	65.9(307)	65.0(238)	76.0(284)	74.0(306)	75.1(582)	4.200	NS
X^2	53.438	21.272	19.859	13.956	22.709		
p	.000	.000	.000	.003	.000		
λ	.079	.007	.000	.000	.004		

Note.[a] Excluded from these data are 16 individuals who did not answer the question. In 1982, 8 subjects did not answer the question; in 1988, 1; in 1991, 1; in 1993, 4; and in 1994, 2.

The sixth hypothesis, that Jewish individuals would be more favorable to euthanasia than persons of other religions, was not supported in the Canadian data. Protestants accepted more than Catholics, followed by Jews. Throughout the American General Social Survey Jews showed the highest support for acceptance of euthanasia, followed by Catholics, and then Protestants which supported H6 (see Tables 11 and 12).

To analyze changes over time by religion row chi square results were calculated for Tables 11 and 12. In both Canada and the United States, Roman Catholic and Jewish individuals who agree with euthanasia were not significant over time. In the case of

Protestants, significant increases in support occurred from the beginning to the ending years of the surveys, but results did not increase evenly from one year to the next (see Tables 11 and 12).

In summary H6 was supported by American respondents, with Jews more favorable to euthanasia than other religions; such differences werre not observed in Canada. Only Protestants showed increased support over time, in both countries.

Table 11

Percentage of Respondents in Canadian Gallup Poll Agreeing that Doctors can End Life, by Religion and Year

Religion	1984(n)	1990(n)	1991(n)	X^2	p
Roman Catholic	69(295)	83(336)	79(307)	25.026	NS
Protestant	73(286)	83(309)	82(299)	110.982	.001
Jewish	63(12)	71(10)	50(2)	6.117	NS
X^2	25.295	27.675	29.872		
p	.013	.035	.003		
λ	.000	.000	.000		

Table 12

Percentage of Respondents in American General Social Survey Agreeing that Doctors can End Life, by Religion and Year[a]

Religion	1982 (n)	1988(n)	1991(n)	1993(n)	1994(n)	X^2	p
Roman Catholic	64.0(247)	72.4(178)	75.7(194)	66.2(143)	70.6(350)	12.614	NS
Protestant	52.8(625)	65.7(372)	71.4(439)	64.6(424)	68.3(740)	87.392	<.001
Jewish	84.8(28)	88.2(15)	95.0(19)	91.3(21)	85.7(36)	1.700	NS
X^2	59.245	13.039	14.769	32.080	39.740		
p	.000	.011	.005	.000	.000		
λ	.000	.000	.000	.000	.000		

Note.[a] Excluded from this data are 22 subjects who did not answer the question. In 1982, 10 individuals did not answer the question; in 1988, 1; in 1991, 1; in 1993, 6; and in 1994, 4.

The seventh hypothesis, that individuals from larger communities would be more accepting of euthanasia than people from small communities or rural areas was analyzed using existing groups available in the data sets from both countries. Column results on Tables 13 and 14 were nonsignificant. Further, row differences in Tables 13 and 14 were also insignificant. The conclusion is that H7 was not supported, that is, no differences by community size were observed in Canada or the United States or over time.

Table 13

Percentage of Respondents in Canadian Gallup Poll Agreeing that Doctors can End Life, by Community Size and Year

Community Size	1984(n)	1990(n)	1991(n)	X^2	p
Over 500,000	68.9(304)	80.4(352)	74.6(314)	4.352	NS
100,000-500,000	57.3(63)	76.7(92)	70.8(85)	5.102	NS
30,000-100,000	66.3(59)	70.0(63)	70.0(63)	9.691	NS
10,000-30,000	63.3(38)	75.0(45)	63.9(39)	6.547	NS
1,000-10,000	66.0 (66)	69.3(70)	68.9(62)	8.742	NS
under 1,000	60.0(150)	83.5(202)	80.8(194)	9.735	NS
X^2	22.880	29.794	23.863		
p	.087	.073	.067		
λ	.000	.000	.000		

Table 14

Percentage of Respondents in American General Social Survey Agreeing that Doctors can End Life, by Community Size and Year

Community Size	1982(n)	1988(n)	1991(n)	1993(n)	1994(n)	X^2	p
Over 500,000	56.9(149)	72.4(63)	70.5(79)	61.0(61)	68.0(138)	1.309	NS
100,000-500,000	60.3(173)	65.0(89)	80.7(96)	72.7(80)	70.2(224)	2.369	NS
30,000-100,000	60.6(149)	71.6(111)	76.9(140)	72.9(191)	76.8(321)	3.202	NS
10,000-30,000	58.1(179)	68.6(153)	75.3(125)	69.2(128)	69.0(229)	5.068	NS
1,000-10,000	57.4(318)	69.6(172)	70.7(208)	66.7(164)	71.3(290)	8.812	NS
Under 1,000	54.7(58)	67.1(49)	69.3(62)	60.0(57)	68.9(115)	7.927	NS
X^2	1.943	4.560	10.030	11.058	12.075		
p	.857	.803	.263	.272	.148		
λ	.000	.000	.004	.000	.002		

The eighth hypothesis, that married individuals would be more accepting of euthanasia than people of other marital statuses, was not supported in Canada, as shown in column analysis of Table 15. Among United States respondents there were significant column differences as shown in Table 16 but no consistent pattern by marital statuses was shown.

To analyze H8 over time row chi square values (Tables 15 and 16) were

calculated. Results showed Canadian single individuals significantly increased euthanasia support from 73.7% in 1984 to 77.4% in 1991; divorced and widowed individuals showed support in 1984 at 62.7% and in 1991 at 73.3%, a significant increase. No significant changes were found for married or living as married over time. In United States the results showed single individuals significantly increased euthanasia support from 59.9% in 1982 to 75.2% in 1994; married individuals showed support in 1982 at 61.2% and in 1994 at 70.7%, a significant increase. No significant changes were found for divorced or widowed over time.

Table 15

Percentage of Respondents in Canadian Gallup Poll Agreeing that Doctors can End Life, by Marital Status and Year

Marital Status	1984(n)	1990 (n)	1991(n)	X^2	p
Single	73.7(146)	83.9(162)	77.4(127)	38.906	‹.001
Married	62.4(455)	77.3(530)	72.4(498)	42.693	NS
Divorced/widowed	62.7(69)	70.6(84)	73.3(85)	37.381	‹.001
Living as Married	76.9(10)	90.0(45)	86.5(45)	18.378	NS
X^2	15.269	22.266	8.569		
p	.084	.135	.739		
λ	.000	.000	.000		

Table 16

Percentage of Respondents in American General Social Survey Agreeing that Doctors can End Life, by Marital Status and Year

Marital Status	1982(n)	1988 (n)	1991(n)	1993(n)	1994(n)	X^2	p
Single	59.9(199)	71.8(140)	75.7(153)	76.0(300)	75.2(149)	27.753	<.001
Married	61.2(580)	71.5(347)	75.1(386)	66.3(859)	70.7(366)	38.540	<.001
Divorced/widowed	61.1(121)	68.9(84)	77.9(95)	73.0(402)	73.8(103)	18.584	NS
X^2	31.056	9.908	11.396	14.518	9.896		
p	.000	.042	.022	.006	.042		
λ	.019	.000	.000	.000	.000		

The ninth hypothesis was that when simultaneously examining all the predictors of euthanasia acceptance religious affiliation will be the strongest predictor, followed by age over time. When planning multivariate analysis to test Hypothesis 9, age, gender, income, education, religion, community size, and marital status were were considered as predictors. In preparation of variables for the analysis, it was noticed that there were some difficulties. First, a large number of missing responses made the income variable unusable. Second, age was not a continuous variable in the original data set; age was categorized as "50 and over" for Canada. Age groupings, therefore, did not permit meaningful multivariate analysis. Third, bivariate results for marital status were

inconsistent between countries and across years within a country. Fourth, the small number of Jews, especially in Canada, meant that multivariate analysis would be unstable. Based on the lack of meaningful variables for input into multivariate analysis, it was decided not to test Hypothesis 9. There are therefore no results for Hypothesis 9 to report using these data; a need still exists for further research to test the relative effect of predictors of euthanasia acceptance.

Chapter VI

Discussion

In this section results from each of the eight hypotheses will be discussed. It is important to recognize that the euthanasia question was not worded exactly the same in the United States as in Canada, and therefore interpretation of the question by participants may have influenced their responses. Some individuals may interpret the question with only active euthanasia definition in mind when terms such as "mercy killing" are used, while others may think about passive euthanasia. Individuals may be lead to specific responses by how the questions are phrased.

First, when examining age, there was more support for euthanasia from younger individuals than older ones, which contradicts previous research. A reason may be that younger people may be in transition, exploring new life opportunities, which may assist in forming opinions. An explanation of these findings may be found by using a life course perspective. Perhaps young people observe what is happening to grandparents or parents, which may affect their opinions. As older members of the family contemplate their own deaths or deaths of their peers, young people may feel that euthanasia is an acceptable alternative. Another reason for these results may be older individuals are more religious (Seidlitz, et al, 1995). If religion plays a large part in the older person's life there may be less support for euthanasia, particularly for Protestants and Catholics. Additionally, when examining the effects of age, it is important to note age categories existed in the

Canadian Gallup Poll in groups. It was not possible to disaggregate the "50 and over" group. By having more categories, specifically within the older age category, a more accurate portrayal of the senior cohort could have been analyzed.

Second, gender was unrelated to euthanasia attitudes except for the American data in 1982 and 1994, where more men than women were in favor. This supports some literature. Ward (1980) examined the 1977 American General Social Survey and found that men are more likely than women to believe in euthanasia. In addition, Menon (1990) examined the 1988 American General Social Survey and found that more men were likely to support euthanasia attitudes than women. It contradicts previous research from Logue (1991a) who explains that euthanasia is a woman's issue as women live longer than men. A reason may be that both Ward (1980) and Menon (1990) used American data for one year only, and they both used small sample sizes. Another reason for the American results may be that women are not as educated as men (Logue, 1991a). If education plays a smaller part in a woman's life than a man's, there may be less support for euthanasia. According to the life course perspective individuals will change their opinions over time as a result of experience. If women are not furthering their education, they may not get as much experience, thus changing their opinions over time.

Third, income was not found to be significant in regard to euthanasia acceptance in either the United States or Canada except in 1982, where results were not in the expected direction. A reason may be the high number of non-responses which may affect

results. The lack of significance of income does not support the literature. Leinbach (1993) found that income was an important variable when examining independent variables and their importance on euthanasia attitudes. A reason may be that being able to afford or not afford a medical treatment is not an issue. Income may not be as important to individuals as quality of life or faith, for example (Menon, 1990). Furthermore, persons who cannot afford certain techniques may decide to use experimental treatments at a reduced cost. Therefore, individuals with lower incomes may find unconventional sources, outside the established medical system, to either assist with death or prolong living.

Fourth, Canadians appeared to be more accepting of euthanasia than did residents of United States by examining percentages, however, 1991 differences did not appear to be statistically significant. Because of Canadian public health policies, Canadians do not worry about how to finance their final illness, and may feel they have more control over their own deaths than Americans do (Gray, 1996). In this study, 1991 was the only year that could be statistically compared between Canadians and Americans; therefore, more research needs to be done on comparing countries.

Fifth, the results of the American data in regard to education in this study supported previous research, where the higher the education, the more support shown for euthanasia. Weiss (1996) stated the higher a person's educational attainment the more accepting of euthanasia he or she will be. The Canadian results showed no significant

difference in regard to education. This may be because Canadians in these samples were highly educated (see Appendix A). The life course perspective provides a useful reason for the increase in support of euthanasia as educational attainment increases for Americans. As an individual's knowledge increases over time, people gain understanding of serious illness and its effects, so that they are more accepting of euthanasia.

Sixth, the American data supported the expectation that Jewish individuals would favor euthanasia more than Catholics or Protestants. The Canadian data contradicted previous research and expectations. However, these results may be unstable due to the small sample size of Jews in both countries (see Appendices A and B).

Seventh, community size was not related to euthanasia attitudes. This result may be because smaller communities are being influenced by the larger communities through media and travel. Larger communities change and develop over time but with the ability to commute to larger communities it is likely that changing technology and development of new ideas spread to smaller communities. However, some of the beliefs of people in small communities may continue to influence euthanasia attitudes, such as church and family values. Existing literature (Menon, 1990) was not supported by this study in regard to larger communities accepting euthanasia more than smaller communities.

Eighth, the results of marital status did not support previous research. Menon (1990) found that marital status was significantly related to euthanasia. Menon's (1990) finding may be a result of one euthanasia question being asked in Menon's (1990) study.

Individuals may interpret the question differently than the 1993 or 1994 euthanasia questions or the euthanasia question asked through the Canadian Gallup Poll. Another reason may be that Menon (1990) used a smaller sample size, therefore, the results may be unstable.

Other family variables may be important to predict euthanasia attitudes. Future research should use other variables such as number of persons in household and number of children to indicate how integrated people are into a social network. This is important because a mother may not want to leave her children, thus disagreeing with the use of euthanasia. Another possibility is that a mother may not want to burden her children with having to take care of her with a debilitative disease.

Finally, when examining the predictors of euthanasia simultaneously there were problems with some predictor variables in the data set. There were many individuals who did not respond to the income variable; age data were grouped and the category "age 50 and over" was too indistinct, and there were an insufficient number of Jewish individuals. Based on the problems with the predictor variables, multivariate analysis was not done. In addition, there may be interactive effects among variables, such as age, gender and marital status. In future studies it is essential for researchers to examine predictors of euthanasia using multivariate techniques.

Limitations

There are limitations of this research. First, only one question was used to examine

active euthanasia and passive euthanasia was not explored. Second, the quantitative nature of the question meant there was no room for explanation on behalf of the researcher or respondent. Third, definitions of mercy killing or euthanasia were not given to respondents, resulting in their own interpretations. Fourth, the results of this study may not be generalizable to individuals from subcultures within the United States or Canada. For example the Canadian data were gathered from English and French speakers, excluding other language groups. In the United States Spanish-speaking Americans were excluded.

Suggestions for Further Research

Much more needs to be learned about people's opinions toward euthanasia. Longitudinal research may give a more accurate picture of the effects of growing older on acceptance of euthanasia. Longitudinal research may also more accurately test the life course perspective as a theoretical base for the euthanasia opinions. As a person gets older a researcher may be able to test for changes in euthanasia opinions and be able to note whether changes occurring throughout the individuals life has an effect on euthanasia attitudes.

Examining those individuals who report that they are a part of no religious affiliation is important to further research. Those individuals with no religious affiliation were neglected within the samples used and they can add an opposite comparison group to research that states that individuals with a strong religious affiliation do not support

euthanasia opinions.

Finally, an analysis of media coverage of euthanasia is another aspect to be explored. For example, Dr. Kevorkian has been in the media in regards to active euthanasia. It appears to be a negative portrayal of euthanasia as he is portrayed as a vigilante. Currently, Dr. Kevorkian has been convicted of second degree murder and sentenced to 10 to 25 years in jail as the result of his assistance with death (Deathnet, 1999). The link between media coverage and increasing public opinion acceptance should be studied.

Implications

Therapists could use the results of this study to formulate questions about euthanasia with their clients. When presented with full histories of their clients, therapists may begin to learn how to treat individuals who wish to use euthanasia. Since many individuals lack education in this field, therapists can assist with decision making. Therapists can educate on many aspects of death and dying. Therapists can provide support to their clients with the decision the individual has made for their final days, whether it is euthanasia or not.

Family researchers can use these results for further testing. Since the data are in the public domain replication can be done using the same data sets and by adding more current years. This would be useful, since this study showed a change over the years and across two countries. There may be a future transition towards positive opinions towards

euthanasia, which could be used in setting public policy.

Chapter VII

Conclusions

In conclusion, life-sustaining techniques have played a large part in bringing the euthanasia debate to life. Specifically, prolongation of life is a concern for many individuals within society. Society's reactions towards life-sustaining techniques have been primarily focused on the medical, legal, and religious concerns about life and death. This research has added to our knowledge about variables that influence public opinion on euthanasia.

The data for this study were derived from the 1984, 1990, and 1991 Canadian Gallup Poll, conducted annually by the Canadian Institute of Public Opinion at Carleton University. Other data for this study were derived from the 1982, 1988, 1991, 1993, and 1994 General Social Survey of the United States, conducted annually by the National Opinion Research Center at the University of Chicago.

The Canadian Gallup Poll samples consisted of 4,023 respondents who were English and French speaking, 18 years of age or older, and not living in an institution during the years of study. The American General Social Survey sample consisted of 35, 284 respondents who were English speaking people, 18 years of age or older, and not living in an institution within the United States. The data were collected through a telephone interview.

For this research nine hypotheses were developed. To analyze eight of them the

statistical procedures used were cross classification tables, with X^2 and λ for each. The ninth hypothesis was not tested. Multivariate analysis was not performed, since several variables were not suitable for analysis. Future research ought to test the relative effects of predictors of euthanasia opinions.

The results of this study indicated that in 1991 Canadians showed greater acceptance of euthanasia than did Americans, however, that difference did not appear to be statistically significant. Further results show that in Canada and the United States attitudes toward euthanasia were unrelated to gender, income and community size. In Canada and the United States younger individuals (18- 29 years) were more accepting of euthanasia than middle aged individuals (30- 49 years) and older (50 and over years). In Canada, education was unrelated to euthanasia attitudes, but in the United States the more educated people were more likely to be favorable towards euthanasia. In Canada there was no relationship between marital status and attitudes towards euthanasia; in the United States there was an unclear relationship as it differed among the years of polling. In Canada, Jews were less positive toward euthanasia than Catholics and Protestants, but in the United States the Jews were the most positive of the three religions. It is suggested that further research link public opinion poll results to public policy changes and that multivariate predictors of euthanasia opinions be tested.

References

American Medical Association. (1996). Code of Ethics: Current Opinions with Annotations. Chicago, IL: Council on Ethical and Judicial Affairs.

Areen, J., King, P., Goldberg, S., & Capron, A. (1984). Law, Science and Medicine. New York: Foundation Press Inc.

Arras, J., & Rhoden, N. (1989). Ethical Issues in Modern Medicine. Mountain View, CA: Mayfield Publishing.

Beauchamp, T., & Veatch, R. (1996). Ethical Issues in Death and Dying. Upper Saddle River, New Jersey: Prentice-Hall Inc.

Bengtson, V., & Allen, K. (1993). The life course perspective applied to families over time. In P. Boss, W. Doherty, R. LaRossa, W. Schumm, & S. Steinmetz (Eds.), Sourcebook of Family Theories and Methods (pp.469-499). New York: Plenum Press.

Christian Medical Fellowship (1997). Twelve reasons why voluntary euthanasia should not be legalised. [On-line], 1-7. Available: www.cmf.org.uk/ethics/twelve.htm

Coleman, G. (1985). Catholic theology and the right to die. Health Progress , 28-48.

Deathnet (1999). In Latest News Bulletins [On Line]. Available: www.rights.org/deathnet/open.html.

Department of Bioethics. (1992). Code of Ethics: Ethics Codes, Standards and Guidelines for Professionals Working in a Health Care Setting in Canada. Toronto, ON:

Hospital for Sick Children.

Dickinson, G., Leming, M., & Mermann, A. (1994). Dying, Death, and Bereavement. Guilford, Connecticut: Dushkin Publishing.

Gray, C. (1996). Health care the tie that binds. Canadian Medical Association Journal, 155(3), 274.

Gruman (1982). Death and Dying. Encyclopedia of Bioethics, 216-268.

Hadjistauropoulos, T. (1996). The systematic application of ethical codes in the counseling of persons who are considering euthanasia. Journal of Social Issues, 52(2), 169-188.

Humber, J. M., Almeder, R. F., & Kasting, G. A. (1993). Physician-Assisted Death. Totowa, New Jersey: Humana Press.

International Anti-Euthanasia Task Force (1998). News notes. [On-line], 13. Available: www.iaetf.org/iua13.htm

Jecker, N. (1994). Physician-assisted death in the Netherlands and the United States: Ethical and cultural aspects of health policy development. Journal of the American Geriatrics Society, 42, 672-678.

Larue, G. A. (1985). Euthanasia and Religion. Los Angeles, CA: Hemlock Society.

Law Reform Commission of Canada (1982). Euthanasia, Aiding Suicide and Cessation of Treatment. Ottawa, ON: Minister of Supply and Services Canada.

Leinbach, R. M. (1993). Euthanasia attitudes of older persons. Research on Aging,

15(4), 433-448.

Lo, B., & Jonsen, A. R. (1980). Clinical decisions to limit treatment. Annals of Internal Medicine, 93, 764-768.

Logue, B. J. (1991a). Taking charge: Death control as an emergent women's issue. Women and Health, 17(4), 97-121.

Logue, B. J. (1991b). Death control and the elderly. International Journal of Contemporary Sociology,28(1), 27-56.

Menon, G. (1990). Social Integration, Age Groups, and Attitudes Towards Euthanasia. Unpublished doctoral dissertation, University of Akron, United States.

Ontario Consultants on Religious Tolerance (1995). Euthanasia and physician assisted suicide: All sides. [On-line], 1-14. Available: www.religioustolerance.org

Ostheimer, J. M. (1980). The polls: Changing attitudes toward euthanasia. Public Opinion Quarterly, 44, 123-128.

Ostheimer, J. M., & Moore, C. L. (1981). Correlates of attitudes toward euthanasia. Social Biology, 28(1-2), 145-149.

Post, S. G. (1990). Severely demented elderly people. Journal of American Geriatrics Society, 38, 715-718.

Prado, C. G. (1990). The Last Choice. Westport, CT: Greenwood Press.

President's Law Commission (1983). Deciding to Forego Life Sustaining Treatment. Washington, DC: U.S. Government Printing Office.

Research Branch of the Library of Parliament (1995). Euthanasia and Cessation of Treatment. Ottawa, ON: Minister of Supply and Services.

Roberts, C. S., & Gorman, M. (1996). Euthanasia. Santa Barbara, CA: ABC-Clio Inc.

Schonwetter, R. S., Walker, R. M., Kramer, D. R., & Robinson, B. E. (1994). Socioeconomic status and resuscitation preferences in the elderly. Journal of Applied Gerontology, 13(2), 157-171.

Seidlitz, L., Duberstein, P. R., Cox, C., & Conwell, Y. (1995). Attitudes of older people toward suicide and assisted suicide. Journal of the American Geriatrics Society, 43(9), 993-998.

Shuman, C., Fournet, G., Zelhart, P., Roland, B., & Estes, R. (1992). Attitudes of registered nurses toward euthanasia. Death Studies, 16(1), 1-15.

Singh, B. (1979). Correlates of attitudes toward euthanasia. Social Biology, 26(3), 248-253.

Smith, M., Alter, S., & Harder, S. (1995). Euthanasia and Cessation of Treatment. Ottawa, ON: Canada Communication Group Publishing.

Sonnenblick, M., Friedlander, Y., & Steinberg, A. (1993). Dissociation between the wishes of terminally ill patients and decisions by their offspring. Journal of American Geriatrics Society, 41, 599-604.

Special Senate Committee (1995). Of Life and Death. Ottawa, ON: Minister of

Supply and Services.

Ward, R.A. (1980). Age and acceptance of euthanasia. Journal of Gerontology, 35(3), 421-431.

Webster's New World Dictionary (2nd ed.). (1984). New York: Simon & Schuster, Inc.

Weiss, G.L. (1996). Attitudes of college students about physician assisted suicide: The influence of life experiences, religiosity, and belief in autonomy. Death Studies,20, 587-599.

Wickett, A. (1988). The mercy killer: Cold blooded or compassionate? The Euthanasia Review, 1, 20-32.

Appendix A

Sample Description for Canadian Gallup Poll in Percentages

Allowing Doctor's to End Life	1984 (n)	1990 (n)	1991 (n)
Yes	64.8 (680)	78.4(824)	74.1(757)
No	25.0 (262)	18.0(146)	17.3(177)
Total (N)	(1050)	(1051)	(1022)
Age			
18-29 Years	24.5(186)	20.6(174)	21.5(172)
30-49 Years	38.5(277)	44.6(399)	41.9(337)
50 and Over	35.9(212)	34.2(251)	35.7(248)
Total (N)	(1050)	(1051)	(1022)
Gender			
Male	50.4(347)	50.0(418)	50.3(382)
Female	49.6(333)	50.0(406)	49.7(375)
Total (N)	(1050)	(1051)	(1022)

Appendix A - continued

Income	1984(n)	1990(n)	1991(n)
Under 10,000	12.1(80)	4.5(35)	3.7(27)
10-14,999	9.2 (57)	5.7(39)	7.4(57)
15-19,999	7.6 (45)	6.3(50)	7.5(55)
20,000 and Over	54.9(498)	67.3(582)	64.3(618)
Total (N)	(1050)	(1051)	(1022)
Education			
Public Grades 1-8	19.3(117)	11.3(85)	11.8(76)
Secondary School 9-13	45.6(316)	44.1(382)	40.8(314)
Post Secondary	34.6(242)	44.1(353)	47.2(364)
No Formal Schooling	.2(2)	.2(2)	.1(1)
Total (N)	(1050)	(1051)	(1022)
Religion			
Roman Catholic	44.2(295)	42.0(336)	41.1(307)
Protestant	42.5(286)	38.2(309)	39.6(299)
Jewish	2.3(12)	1.4(10)	.7(2)
Other	11.0(57)	18.4(193)	18.6(190)
Total (N)	(1050)	(1051)	(1022)

Appendix A - continued

Community Size	1984(n)	1990(n)	1991(n)
Over 500,000	42.0(304)	41.7(352)	41.2(314)
100,000-500,000	10.5(63)	11.4(92)	11.7(85)
30,000-100,000	8.5 (59)	8.6(63)	8.8(63)
10,000-30,000	5.7 (38)	5.7(45)	6.0(39)
1,000-10,000	9.5(66)	9.6(70)	8.8(62)
Under 1,000	23.8(150)	23.0(202)	23.5(194)
Total (N)	(1050)	(1051)	(1022)
Marital Status			
Single	18.9(146)	18.4(162)	16.0(127)
Married	69.4(455)	65.3(530)	67.3(498)
Divorced/widowed	10.5(69)	11.3(84)	11.4(85)
Living as Married	1.2 (10)	4.8 (45)	5.1(45)
Total (N)	(1050)	(1051)	(1022)

Appendix B

Sample Description for the American General Social Survey in Percentages

Allowing Doctor's to End Life	1982(n)	1988(n)	1991(n)	1993(n)	1994(n)
Yes	58.2(1026)	69.3(648)	73.8(719)	68.3(696)	71.3(1334)
No	41.8(737)	30.7(287)	26.2(255)	31.7(323)	28.7(537)
Total (N)	(1763)	(935)	(974)	(1019)	(1871)
Age					
18-29 Years	26.9(317)	24.1(178)	20.1(157)	18.8(161)	17.4(254)
30-49 Years	34.0(375)	48.9(263)	43.8(334)	44.5(319)	46.1(642)
50 and Over	39.1(334)	27.0(207)	36.1(228)	36.7(216)	36.5(438)
Total (N)	(1763)	(935)	(974)	(1019)	(1871)
Gender					
Male	41.9(464)	43.1(307)	41.9(313)	42.7(325)	43.1(587)
Female	58.1(562)	56.9(341)	58.1(406)	57.3(371)	56.9(747)
Total (N)	(1763)	(935)	(974)	(1019)	(1871)

Appendix B - continued

Income	1982(n)	1988(n)	1991(n)	1993(n)	1994(n)
Under 10,000	39.4(267)	28.4(117)	25.2(121)	21.0(113)	20.8(192)
10,000-14,999	19.9(139)	14.9(69)	12.5(63)	11.2(47)	11.6(121)
15,000-24,999	24.1(197)	24.0(116)	24.3(121)	23.9(114)	23.2(226)
25,000 and Over	12.1(90)	28.2(134)	33.7(163)	39.4(195)	38.9(390)
Total (N)	(1132)	(627)	(626)	(686)	(1302)
Education					
Public Grades 1-8	14.5(98)	10.6(48)	8.0 (41)	7.9(49)	6.5(68)
Secondary School 9-13	59.2(98)	54.9(362)	53.4(394)	51.3(340)	52.4(684)
Post Secondary	26.0(307)	34.4(238)	38.5(284)	40.6(306)	41.1(582)
No Formal	.4(1)	.1(1)	.1(1)	.2(2)	.1(2)
Total (N)	(1763)	(935)	(974)	(1019)	(1871)
Religion					
Roman Catholic	21.6(247)	25.9(178)	25.5(194)	22.0(143)	25.5(350)
Protestant	68.1(625)	61.2(372)	63.8(439)	64.2(424)	59.5(740)
Jewish	2.1(28)	2.0(15)	2.1(19)	2.1(21)	2.0(36)
Other	8.2(42)	10.8(24)	8.6(29)	11.7(118)	13.1(144)
Total (N)	(1763)	(934)	(973)	(1013)	(1867)

Appendix B - continued

Community Size	1982(n)	1988(n)	1991(n)	1993(n)	1994(n)
Over 500,000	15.1(149)	9.7(63)	12.4 (79)	10.9(61)	11.4(138)
100,000-500,000	16.3(173)	16.6(89)	15.8(96)	12.4(80)	17.5(224)
30,000-100,000	13.7(149)	16.6 (111)	16.3(140)	25.4(191)	22.1(321)
10,000-30,000	17.5(179)	23.7(153)	19.0(125)	17.3(128)	17.8(229)
1,000-10,000	31.5(318)	25.2(172)	29.1(208)	24.9(164)	22.5(290)
Under 1,000	6.0(58)	8.3(49)	5.4(62)	9.1(57)	8.7(115)
Total (N)	(1763)	(935)	(974)	(1019)	(1871)
Marital Status					
Single	18.9(199)	20.1(140)	21.4(153)	18.7(300)	20.5(149)
Married	53.4(580)	53.2(347)	53.0(386)	53.5(859)	51.5(366)
Divorced/ Widowed	27.7(121)	26.7(84)	25.6(95)	27.7(402)	27.9(103)
Total (N)	(1763)	(935)	(974)	(1019)	(1871)