

**PUBLIC OPINIONS OF PHYSICIAN-ASSISTED SUICIDE:  
THE ROLE OF AGEISM IN ACCEPTANCE**

By

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**Public Opinions of Physician-Assisted Suicide: The Role of Ageism in Acceptance**

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**Patricia Prosen**

**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 ARTS**

**PATRICIA PROSEN©2005**

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### **Abstract**

The current debate concerning physician-assisted suicide (PAS) provided an opportunity to investigate the impact of ageist attitudes on older Canadians. The 2000 Winnipeg Area Study, a telephone survey conducted by the University of Manitoba of 750 Winnipeggers aged 18 and over, was used to gather data. Three research questions about the acceptability of PAS guided the study. Ageism was measured using Palmore's Facts on Aging Quiz and a split-half design that varied the target person as either old (80 years) or young (40 years). Findings revealed that males, younger respondents, and the No Preference religious group were more likely to find PAS acceptable. There was a trend toward greater acceptance of PAS for older target persons.

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## CHAPTER ONE: INTRODUCTION

In Canadian society certain groups are often portrayed in a demeaning way. One group known to be the target of demeaning images and actions is adults age 65 and over. This negative portrayal is believed to contribute to ageism, which is defined as stereotypes, prejudice, and discrimination against older Canadians (Featherstone and Wernick, 1995; Novak and Campbell, 2001). Although there is evidence that ageism exists, researchers disagree about whether these attitudes actually have an impact on older Canadians (Chappell, Gee, McDonald, and Stones, 2003; Novak and Campbell, 2001). As more research is needed on the impact of ageism in Canada, the current debate concerning euthanasia and physician-assisted suicide provides a compelling forum for investigating possible ageist opinions.

A recent Canadian study on cancer patients with advanced cancer who were receiving palliative care found that 73% thought that physician-assisted suicide and euthanasia should be legalized and that 12% would have requested it at the time they were being interviewed (Wilson, Scott, Graham, Kozak, Charter, Viola, deFaye, Weaver, and Curran., 2000). Other earlier studies confirm these findings. For instance, an Angus Reid survey done in the early 1990's reported that 76% of Canadians support the 'right to die' for patients who are terminally ill (Kelner, 1995). A 1995 survey of terminally ill Canadians in Alberta found that a majority favoured legalizing assisted suicide and euthanasia (Frileux, Lelievre, Munoz Sastre, Mullet, and Sorum, 2003). In 1991, Gallup reported that 75% of Canadians supported a patient's request for physician controlled mercy killing while twenty-three years earlier only 45% of Canadians supported mercy killing (Bozinoff and MacIntosh, 1991). From the available data it appears that a

growing number of Canadians support physician-assisted suicide but physician-assisted suicide, assisted suicide, and euthanasia remain illegal.

There is continuing debate about whether Canadians have the right to seek a physician's assistance with death but there are little Canadian data available about physician-assisted suicide. Physician-assisted suicide, or PAS, can be broadly defined as occurring when a physician assists a patient to die and is, in part, both a response to medical advances that would prolong life, and possible because of those medical advances. That is, PAS as it is currently practiced, makes use of different medicines and techniques that were originally developed to treat illness and disease. While Western societies are increasing their dependence on biomedicine for issues and problems traditionally beyond the scope of the discipline, there is growing disillusionment with scientific medicine (Williams and Calnan, 1996).

Among those disillusioned with medicine are opponents to the legalization of physician-assisted suicide who argue that the laws must remain on the books to protect vulnerable people who do not wish to die from others who believe that they "would be better off dead"(Mullens, 1996, p.25). Mullens (1996) notes:

Once we decide on any basis that euthanasia is good for some people, it would be very difficult to say that it was also not good for others. There are many frail and incapacitated people, who, in some people's eyes, are serving no purpose in our society.... The continued safety and protection of large numbers of frail people depends[sic] on the maintenance of the law the way it is. In fact, the recent trial against Saskatchewan farmer Robert Latimer, who admitted killing his disabled daughter, Tracy, to put her out of her pain and suffering, and the widespread support for his actions from the public, confirmed many euthanasia opponents' worst fears that euthanasia would grow to encompass those who do not request it. (p.25)

In the early 1990s, the Supreme Court of Canada expressed similar concerns in the case of Sue Rodriguez when it denied her request for legal permission to have a doctor

assist her suicide<sup>1</sup>. Although the court recognized the devastating nature of her illness, it feared that in granting her permission to seek a physician's assistance they would be setting a dangerous precedent making the elderly and the disabled especially vulnerable (Birnle and Rodriguez, 1994). The concerns expressed by the Supreme Court of Canada are consistent with what is frequently referred to in the literature as the 'slippery slope'. The 'slippery slope' argument warns that allowing physicians to assist terminally ill persons to die will eventually lead to the indiscriminate killing of vulnerable and devalued people like the elderly (Moody, 1984; Palermo, 1995; Schneewind, 1994; Smith, 1997).

People who are suffering are vulnerable as are those who are devalued by society. These people may be disabled, mentally incompetent, and/or aged. They may be suffering from physical or emotional pain. A recent study found that depressed older patients were 13 times more likely to agree to PAS in their current state and twice as likely to agree to PAS when they were asked to imagine themselves diagnosed with a terminal illness or in a coma (Blank, Robinson, Doherty, Prigerson, Duffy, and Schwartz, 2001).

There is concern that in certain situations, vulnerable persons may not choose euthanasia but will have it chosen for them. The fear is also that euthanasia will be presented to vulnerable persons as the rational alternative to alleviate their suffering. In other words, there will be an erosion of the distinction between voluntary and non-voluntary euthanasia. It may become too easy "for societal values to shift from the

<sup>1</sup> Susan Rodriguez was terminally ill with the disease amyotrophic lateral sclerosis (ALS) which has also been called Lou Gehrig's disease.

recognition of an individual's right to die to a climate of enforcing a social obligatory duty to die" (Moore, 1995, p. 206).

If the 'slippery slope' argument is correct then persons devalued by society are vulnerable to greater acceptance of PAS than those who are not devalued by society. The 'slippery slope' argument would predict a greater acceptance of PAS for older adults where ageism is present. However, there are little data available on the relationship between ageism and PAS, which is the topic addressed in this research.

This research will contribute to the gap currently existing in the literature. Its objective is to examine the relationship between ageism and acceptance of PAS.

The four research questions are:

1. In Winnipeg, is the general public in favour of PAS?
2. Does the general public indicate differences in acceptance of PAS for those who are 80 years old compared to those who are 40 years old?
3. Does the general public indicate differences in acceptance of PAS for those who are in pain and are 80 years old compared to those who are in pain and are 40 years old?
4. What is the relationship between select socio-demographic characteristics and the acceptance of PAS? Specifically, age, income, gender, health status, and religion will be addressed.

The data for this study were collected by the Winnipeg Area Study (2000). The Winnipeg Area Study (WAS) is a telephone survey conducted by the Sociology department at the University of Manitoba using a random sample of 750 residents. The results of this study on ageism and acceptance provide the basis for this thesis.

This thesis is organized as follows. In Chapter Two, the existing literature is reviewed. Chapter Three explains the research methodology and is followed by Chapter Four which describes the Sample Characteristics. Chapter Five presents the findings of the research questions. Chapter Six includes the discussion and conclusion, as well as the study's implications, recommendations, and limitations.

## CHAPTER TWO: REVIEW OF THE LITERATURE

### Introduction

The right to die debate encompasses a variety of terms. This chapter begins with definitions of the key concepts used for this research. A discussion of ageism and a review of the rationing of health care debate follow. The history of the debate concerning PAS is offered, as is the 'right to die' debate and the death with dignity argument. Comparisons between Canada and other jurisdictions are included. The research questions follow and a brief summary ends the chapter.

### Definitions

The right to die debate currently encompasses the issues of assisted suicide, physician-assisted suicide (PAS), passive euthanasia, active euthanasia, voluntary and involuntary euthanasia. Assisted suicide occurs when someone supplies the way for another to commit suicide and physician-assisted suicide involves the assistance of a physician in the suicide.

The word euthanasia is Greek and means good death (Novak and Campbell, 2001). There is often a distinction made between passive and active euthanasia (Novak and Campbell, 2001; Secouler, 1998). Passive euthanasia includes the removal of life support and/or the withholding of life-saving treatment. It is called passive euthanasia because the person dies of the disease or illness rather than from an action such as the administration of a lethal drug. Active euthanasia occurs when one individual takes direct action that results in a person's death. The active form of euthanasia has become a

major part of the 'right to die' debate because it involves a direct action, for example the administration of lethal drugs to a terminally ill patient by a physician or someone else, which results in the death of another (Hanks, 1995). Euthanasia is called voluntary when patients express a desire to die whereas involuntary euthanasia occurs if patients have not expressed a desire to die (Guedj, Gibert, Maudet, Munoz Sastre, Mullet, and Sorum, 2005).

### **Ageism**

In 1968, Robert Butler was the first to use the term ageism to identify the stereotypes assigned to adults as they grow older (Butler, 2005). Ageism, or discrimination, prejudice, and stereotypes against older persons is institutionalized and visible in technologically advanced, Western countries (Falk and Falk, 1997). Western culture often perceives the aging body negatively because it is not seen as normal, or in other words, not young (Lupton, 1996; Novak and Campbell, 2001). Ageism is said to be responsible for the belief that people, 'cease to be people or become people of a distinct and inferior kind, by virtue of having lived a specified number of years' (Secouler, 1998, 11). Ageism is, in part, one expression "of a larger backlash against an artificially homogenized group labeled 'the aged', which has become a scapegoat for a variety of problems in American society during the past decade" (Binstock and Post, 1991,1). Similarly, in Canada, newspaper stories have stated that older persons are responsible for the rising cost of health care (Novak and Campbell, 2001). Like all prejudices, ageism can have an effect on how the victim perceives herself or himself. The older individual may adopt the negative definitions attributed to him/her and may perpetuate the negative

stereotypes, which in turn help to reinforce society's beliefs (Falk and Falk, 1997) and may cause older persons to disengage from participation in social groups (Osgood, 2005).

The stereotypes of older adults are said to have undergone a change since the 1980's when the rationing health care debate began to emerge (Binstock and Post, 1991). The debate about rationing health care and about rational assisted suicide on the grounds of old age can be seen as one expression of ageism (Moore, 1995; Schneewind, 1994).

According to Schneewind (1994), arguments that state that the old should stop trying to be young and should stop selfishly demanding resources that would be better used on the young are subscribing to the "new ageism". The "new ageism" artificially homogenizes older adults as 'the aged' and stereotypes them as selfish, hedonistic, and prosperous (Binstock and Post, 1991).

The debate on rationing health care for the elderly has become significant in the literature and demonstrates the degree of controversy that exists around the issue of allocation of resources. Its significance to the PAS debate lies in the belief, by at least some, that the number of years lived is the most significant determinant in how health care resources should be allocated.

When health care policies discriminate on the basis of age, it is an example of the devaluing of persons on the basis of age (Schneewind, 1994). Some say that a society that devalues old age is more likely to permit its physicians to assist in their death (Palermo, 1995), which may make this age group vulnerable to changes in existing PAS legislation (Schneewind, 1994). According to Binstock & Post (1991), governments, insurers, and health care professionals are responding to the economic pressures of increased longevity, growing health-care costs, and life-extending medical technology by

setting limits on the health care available to those 65 and over. There is concern that in the future economic considerations will become the primary criteria for medical treatment (Schneewind, 1994). The evolution of medical technology and increased longevity have helped to change death and dying.

### **History of the Debate**

Prior to advances in technology and the hospital becoming the place in which most of us die, people often died at home surrounded by their family (Charmaz, 1980). Death occurred in the same place that one lived and was a natural ending to life.

Advanced technology and improved medical treatments have enabled doctors to prolong and extend life. "Nowadays, the progress of medical science and technology offers new therapeutic alternatives creating medical and ethical choices that did not exist before" (Saint-Arnaud, 1995, 394). Many people have lived longer lives due, in part, to medical advances but some of that extension of life has been accompanied by increased suffering. The progress of medical science has also increased anxiety among older patients that they may be maintained for extended periods on life support (Frileux et al, 2003). There are increasing calls for better palliative care for the dying indicating a strong dissatisfaction with how the process of dying is being treated by the medical community.

The advance of modern medicine has led to the medicalization of death, which can be defined as "a process whereby more and more of life comes to be of concern to the medical profession" (Clarke, 1996, 238). Legalizing physician-assisted suicide is medicalizing suicide, that is, using modern technology and medical knowledge to

practice suicide. As noted by Salem (1999), if the physician is responsible, “either by his or her physical presence or by supplying the medical means to perform the act” then physician-assisted suicide will result in medicalizing the act of suicide (p. 34). The act of suicide is part of the ‘right to die’ debate.

### **The Right to Die**

The debate on the ‘right to die’ is based on the larger ideology of the individual’s right to live as he or she chooses (Palermo, 1995). This is also referred to as individualism and is a current theme in Canadian society (Smith, 1997). Saint-Arnaud (1995, 393) notes:

The principal of personal autonomy, from which the legal principle of self-determination is derived, is based on the rational nature of human beings and on the ability of each individual to make choices and set goals for oneself. In the area of health, recognition of personal autonomy is a recent American phenomenon, which is becoming widespread in Canada.

In contemporary Western society there is a belief that individuals have the right to make their own decisions about medical treatment (Kelner, 1995). Research indicates that patient request is the most powerful predictor of acceptability for PAS and euthanasia (Frileux et al., 2003). One Canadian study looked at views of hospitalized older patients concerning control over end-of-life decisions and found the majority could be categorized as ‘activists’, defined as individuals who prefer to have a say in decisions made at the end of life (Kelner, 1995). Although activists rejected the idea of euthanasia, they supported the idea of withholding treatment that would prolong life beyond their wishes (Kelner, 1995).

Many Canadians wish to have a say in their end-of-life medical care. Advance directives, living wills, and durable powers of attorney are ways in which persons convey

their wishes should they become unable to communicate. In Manitoba, the government has passed the *Health Care Directive Act*, which legislated the individual's right "to self-determination, or the right to individual autonomy" (Manitoba Law Reform Commission Report, 1991, 3). For the first time Manitobans had the right not only to determine their current medical treatment, but also to control future treatment, should they become incompetent.

People elsewhere in the world express a similar desire to exert greater control over the process of dying. Recently, in France, a physician assisted a severely disabled man to die who had made several suicide attempts and although opinion polls indicate a majority of public support, the government remains opposed to the physician's actions (Burgermeister, 2003).

In the U.S., federal Appellate courts ruled that terminally ill patients have the right to seek a doctor's assistance in ending their lives (Butler, 1996; Carter, 1996). In 1997, residents of Oregon passed the Death with Dignity Act making it the first American state to officially recognize an individual's right to PAS, but they did not legalize euthanasia like the Netherlands. Requests for PAS have increased in Oregon since it has been legalized although the numbers remain quite small. For instance, in 2003, out of 31,000 deaths, 42 patients used PAS (Oregon Department of Human Services, 2004). Some are wondering if Oregon will follow the same trend as the Netherlands, which saw an increase in PAS for 15 years following legalization (Walsh and Hendrickson, 2003). It has been recently reported that the rate of euthanasia and requests for PAS in the Netherlands appear to have leveled off since 1995 and that physicians appear to have become more reserved in their use of PAS and euthanasia (Onwuteaka-Philipsen, van der

Heide, Koper, Keij-Deerenberg, Rietjens, Rurup, Vrakking, Georges, Muller, van der Wal, and Maas, 2003).

Also in the United States, the very high profile and controversial cases involving the physician, Dr. Jack Kevorkian<sup>1</sup>, have helped to promote the issue of physician-assisted suicide. Dr. Kevorkian calls physician-assisted suicide “medicide” and believes that it should be a specialty practiced by medical technicians at “suicide centres” (Wolfson, 1998). Many of the cases in which he has been involved have been highly publicized. Dr. Kevorkian publicly acknowledges that he has helped at least 130 people to die by assisted suicide (Gianelli, 1998) and strongly believes in an individual’s right to self-determination (Kevorkian, 1991).

Dr. Kevorkian had been tried and acquitted on three occasions for his participation in suicides until 1999 when he publicly administered a lethal injection to a terminally ill man (Gianelli, 1998). As a result, he was convicted in April of 1999 of second-degree murder and was imprisoned. Adding further controversy to Dr. Kevorkian’s actions is recent evidence suggesting that only 17 of the 69 cases were terminally ill and five did not have any disease apparent in autopsy (Priest, 2000). According to the literature Dr. Kevorkian is not alone as many as 25% of physicians in the U.S. say that they have helped a patient die (Hendin, 1998). There is no way of knowing how many physicians are helping patients to die but are unwilling to report it.

Recently, in the United States, the debate about euthanasia and PAS was focused on

<sup>1</sup> Dr. Kevorkian has been called the suicide doctor and doctor death because of his involvement in numerous high profile physician-assisted suicides. (Wolfson, 1998).

Terri Schiavo<sup>3</sup> who died after her feeding tube had been removed on March 18, 2005 (Quill, 2005). This was an instance of passive euthanasia and was the third time that her feeding tube had been removed due to an ongoing legal battle between her parents and husband involving the courts, the U.S. Congress, the Governor of Florida, and the President of the United States (Quill, 2005). This was the first time in the history of the United States that Congress met in a special emergency session in order to pass legislation addressing the medical care of a single person (Annas, 2005).

In Canada, a high profile case of active euthanasia that attracted both media and public attention was that of Robert Latimer. In 1993, Robert Latimer placed his severely disabled daughter in his truck and filled the cab with deadly exhaust fumes (Wolfson, 1998). His 12-year-old daughter Tracy had been suffering from severe cerebral palsy and Latimer stated that he only wanted to end her suffering (Wolfson, 1998). Latimer is currently serving a life sentence for second-degree murder (Samyn, 2001) and the case has fuelled great debate among Canadians. Proponents of Robert Latimer's actions believe that he was sentenced too harshly. Opponents to euthanasia and PAS were particularly alarmed by this case because Tracy Latimer was disabled and incapable of expressing her wishes to anyone.

In the early 1990's, another Canadian's battle with ALS was also highly publicized. Susan Rodriguez sought legal permission to have a doctor assist her in terminating her own life. She wanted to wait until her quality of life was diminished before committing suicide but knew that she would be physically unable to end her life when the time came

<sup>3</sup> Terri Schiavo, a 39 year old woman, had been left in an irreparable vegetative state since 1990 when her heart stopped for a period of time in 1990 (Goodnough, 2003).

(Birnie and Rodriguez, 1994). With some initial support of “The Right to Die Society of Canada” she took her request first to the courts in B.C. and then to the Supreme Court of Canada. Although the courts decided against her, a physician who has remained anonymous helped her to die on Feb. 12, 1994.

Susan Rodriguez felt that she had the right to decide how and when she would die (Birnie and Rodriguez, 1994). Her lawyer argued that the criminal code, which made it illegal for a physician to aid and counsel a patient about suicide was against the Charter of Rights and Freedoms (Birnie and Rodriguez, 1994). Three points that are often argued by proponents of euthanasia were made. They are that a person has the right to live and die with dignity, that a person has the right to control what happens to their body while they are alive, and that a person has the right to be free from government intervention or interference (Birnie and Rodriguez, 1994). Although the courts agreed that Rodriguez’s disease was devastating and would cause her great suffering, they feared that if they granted her permission to seek a doctor’s assistance they would be setting a dangerous precedent (Birnie and Rodriguez, 1994). The courts felt that the disabled and the elderly may be especially vulnerable if euthanasia was condoned by the law, and that such a change was the responsibility of parliament not the courts (Birnie and Rodriguez, 1994). There have been other court decisions in the United States that support a similar position that legalizing assisted suicide and euthanasia would create a profound risk to the frail elderly (Smith, 1998).

The concerns of the Supreme Court of Canada are consistent with the “slippery slope” argument. In other words, there is a fear that over time very restrictive guidelines on euthanasia and physician-assisted suicide will become relaxed, as some say they have in

the Netherlands (Zehetmayr, 1996). The worry is that as assisted suicide becomes more widely accepted it will not be just for those who are terminally ill but will be for anyone suffering from a hopeless illness, “both as a beneficence for suffering individuals and a good for society as a whole that will reduce health-care costs and the burdens of care on society and families” (Smith, 1997).

Suicide and assisted suicide have been called forms of death control, which can be defined as deliberate behaviour that results in a hastened death for a person suffering from a terminal illness or from the degeneration that occurs as a person ages (Logue, 1993). Logue (1993, 6) states:

Since death in advanced industrial societies is concentrated at the older ages, death control is most salient for the elderly....Decisions in these cases and decisions for the elderly influence and reinforce one another, helping to legitimate death control, but the elderly, especially the oldest and frailest among them, remain the largest group affected by such choices.

Recent research has shown that age of the patient is one factor influencing people’s judgement of the acceptability of PAS (Frileux et al., 2003).

End of life concerns are relevant for the elderly who most bureaucratic institutions in Canada identify as those 65 years of age and over. The elderly in Canada would be greatly affected by changes in legislation allowing a doctor to assist a suicide or to perform euthanasia in cases of prolonged suffering associated with dying. There are those who believe that changes to PAS and euthanasia legislation would provide certain individuals greater control over their own death, which may provide for a more dignified death.

### **Death with Dignity**

'Right to die' advocates believe that PAS should be legalized because the individual has the right to die with dignity (Ross and Kaplan, 1994). This is especially relevant for the elderly who fear becoming a burden and experiencing a loss of dignity (Krant, 1974).

A good death or death with dignity is a subjective concept. Recent research of patients receiving excellent palliative care found that a preserved sense of dignity is, in most instances, the norm for most patients who are dying (Chochinov, Hack, Hassard, Kristjanson, McClement, and Harlos, 2002).

There are physicians who believe that dignity comes from accepting what the body does at the time of death and not fighting the process (Sheehy, 1981). According to Nulland (1995), from a physiological standpoint there is no such thing as a good death and euthanasia may have value because it provides greater comfort to friends and family. Recent research from the Netherlands has provided support to Nulland as it indicates that family and friends of cancer patients who died by euthanasia performed by a physician, which was defined as the intentional ending of a patient's life at her or his request, had less traumatic grief and coped better than those who died from natural death (Swarte, van der Lee, van der Boom, van der Bout, and Heintz, 2003).

Both sides of the PAS debate seek to solve the dilemma of human existence with control (May, 1996). It is generally believed that doctors know how to make the process of death easier because they often control the technology and can make life or death decisions. Many fear that this authority will be abused should legislation be passed that permits a doctor to euthanize a patient who is no longer capable of expressing his/her wishes (Moody, 1984).

To view the practice of voluntary euthanasia as only an expansion of the person's right to self-determination "may reflect an extremely naive view of the uncoerced nature of the decision" (May, 1996, 26). If the person requesting euthanasia is making the request because they fear neglectful and inadequate care while dying then the decision cannot be thought of as unforced (May, 1996). Family members, financial pressures, and the physician may all influence a patient's decision (Hunter, 2000). A person's decision may also be influenced by suffering and pain. Recent research has found that terminally ill cancer patients have a highly unstable will to live and that requests for death may be transient (Chochinov, Tataryn, Clinch, and Dudgeon, 1999)

### **Pain and Suffering**

Some believe that suicide is not a solution for suffering. Rather, proper care of the dying will decrease the desire for suicide (Kazanowski, 1977; Miller, 1997; Sequin, 1994). Older research indicated that fear of the unknown and pain play a significant role in why people fear death (Stern, 1984). When people are offered a pain free way to die naturally they often change their minds about suicide (Butler, 1996; Novak and Campbell, 2001). A recent study on the characteristics of patients requesting PAS found that persons were more likely to request assistance if they were seriously ill, had a life expectancy of less than one month, and in severe pain (Meier, Emmons, Litke, Wallenstein, and Morrison, 2003). According to Quill (2004), it is not untreated pain that motivates patients to choose PAS, but a loss of autonomy, loss of control of bodily functions, tiredness of dying, and decreased capacity to enjoy life. Correspondingly, a recent study found that other factors such as not becoming addicted to the pain

medication were more important than pain relief in quality end-of-life care (Weiss, Emanuel, Fairclough, and Emanuel, 2001).

Suffering is subjective in nature and may be physical and/or emotional. Depression is thought by some to be one stage that people go through when they are dying (Kubler-Ross, 1969). Others feel that individuals do not necessarily work through the depression associated with dying (Stephan and Stephan, 1990). This is particularly true for older adults, who have the highest suicide rates and for whom depressive disorders are one of the most common mental illnesses (Abrams, 1998). Clinical depression often goes untreated and is a source of substantial suffering for the older, dying individual (Lander, Wilson, and Chochinov, 2000).

Hospice and palliative care are promoted by many as the most appropriate way to treat the dying. The elimination or reduction of emotional and physical suffering is the major goal of palliative care and hospice, and is the reason that many individuals believe that it is the better alternative for the dying person than physician-assisted suicide or euthanasia (Byock, 1994). Palliative care is “the physical, emotional, spiritual and informational support given to someone who has a terminal or life-threatening illness and to their families” (Seguin, 1994, 114). It may involve professionals from many different fields of expertise like psychologists, physicians, and nurses.

Hospice and palliative care are in essence interchangeable as “hospice care is an interdisciplinary program of palliative care and supportive services that may be provided either in the home or at a hospice centre” (Seguin, 1994, 115). Palliative care is offered in conjunction with active medical treatment of a patient’s disease (Quill, 2004). The

emphasis is on care versus cure and on making the death more comfortable rather than prolonging the process of dying. Quill notes (1994, 78):

In traditional medical care, increased suffering is reluctantly accepted as a side effect of treatment that is directed primarily at extending a patient's life. In comfort care, unintended shortening of the patient's life can be accepted as a potential side effect of the treatment, provided that the primary purpose of the treatment is to relieve suffering. The underlying religious and ethical principle is called the 'double effect', which absolves physicians from responsibility for indirectly contributing to the patient's death.

The Canadian Medical Association recognizes the double effect as acceptable because the primary intention of the physician is to relieve suffering rather than cause death (Lowy, Sawyer, and Williams, 1993).

Hospice and palliative care professionals acknowledge that there are a small minority of cases that do not respond to medication and as a result, they are unable to alleviate all physical suffering (Kazanowski, 1997). Treating pain in the elderly can be complex and more difficult than in younger individuals (Derry, 1997), which may be in part due to their age and more complex medical problems (Ley, 1989). Research has found that good terminal care of the elderly poses tremendous challenges to nurses and doctors (Costello, 2001) and that 87% of 128 nurses and senior nursing students believed that elderly persons experience less pain (Brockopp, Warden, Colclough, and Brockopp, 1993).

There are physicians who believe that in some instances a small number of terminally ill patients are justified in wanting to die and that in these instances PAS should be allowed to help (Rosenthal, 1997). There are others who say that it is not necessarily an either/or proposition, that is, hospice and palliative care or assisted suicide (Miller, 1997). In these instances hospice care and assisted suicide are a false dichotomy because it

promotes hospice as the only moral choice (Miller, 1997). According to Quill (2004), data gathered from Oregon over a five year period indicate hospice and PAS to be compatible.

Hospice and palliative care are possible options for end of life care in Canada. In the Netherlands there are other options for those who are suffering from unbearable pain because of a terminal illness.

### **The Netherlands**

The Netherlands has recently passed legislation that designates it as the first country in the world to legalize euthanasia (Priest, 2000). The new legislation will allow children as young as 12 to receive euthanasia and recognize "euthanasia declarations", or requests by persons no longer able to express their wishes (Iley, 1999). Physicians in the Netherlands have been able to practice euthanasia and/or PAS in certain narrowly defined situations without fear of prosecution since 1984.

The Royal Dutch Medical society and the Dutch Courts have established similar rules for physicians to adhere to whether they are practicing euthanasia or assisted suicide (Hendin, 1998). The requests must be made voluntarily and persistently and the physician must consult with a colleague (Hendin, 1998). Other guidelines required by Dutch Law are that the patient must be in untreatable and unbearable suffering, that consent is informed, and that the act of euthanasia is performed carefully (Hunter, 2000).

The Netherlands has government-subsidized health care like Canadian Medicare but it is more extensive because all health care costs are covered regardless of where they are incurred (Sneiderman, 1994). In contrast, in Canada, increasingly over the past few

years, individuals have had to supplement health care costs. Complete health care coverage ensures that the individual is not seeking out suicide as a response to economic pressures. Another difference between Canada and the Netherlands is that in the latter the general practitioner has a high degree of contact with his/her patient, making house calls and living in the neighbourhood in which they practice. This means that he/she has a more intimate knowledge of his/her patients often knowing the patient and family for many years and as a result, the doctor is more capable of evaluating the reasonableness of a patient's request for euthanasia (Sneiderman, 1994).

There has been discrepancy in the reported figures on euthanasia and assisted suicide in the Netherlands. One report from the early 1990s noted that there had been 2,300 cases of euthanasia a year since 1991 (Zehetmayr, 1996). Other figures from physicians state that 3,600 or 3% of all deaths each year are the result of euthanasia or assisted suicide (Iley, 1999). There are those who believe that a significant number of cases of euthanasia, up to 50% are not being reported, even though it is illegal to fail to report them (Zehetmayr 1996). In response to patient's concerns about involuntary euthanasia the Dutch Patients Association issues a 'passport for life' that asks that the bearer not be euthanized (Hunter, 2000).

There are conflicting reports from the Netherlands. A 1997 study that examined the relationship between euthanasia and/or physician-assisted suicide in the Netherlands and the age of the person to whom it was administered found that euthanasia and/or physician-assisted suicide is more often performed on men than women and on adults in the age categories of 60 to 69 and 70 to 79, but less frequently on adults 80 and older (Onwuteaka-Philipsen, Muller, and van der Wal, 1997). Another study on euthanasia in

the Netherlands found that the average age for euthanasia and assisted suicide is 62 for men and 65 for women (Zehetmayr, 1996), which supports the argument that the frailest old are not the most affected by more permissive attitudes toward euthanasia. It does, however, indicate that PAS is more frequently performed on older persons.

### **Summary and Limitations of the Reviewed Literature**

In summary, the literature on PAS is considerable and reveals the profound nature of the argument. The debate encompasses many concepts and issues, some of which are not completely understood like the concept of death with dignity. More research is needed to clarify the issue of PAS. More research is needed to clarify the role that ageism plays. Are older persons more vulnerable to changes to PAS legislation? Does ageism influence opinions about PAS?

### **Research Questions**

Although the literature suggests that an age bias may lead to the indiscriminate use of PAS against older individuals there are little Canadian data to support the argument. The objective of this research is to examine if an age bias exists in opinions of the general public toward the acceptance of PAS. Previous research has indicated that including unbearable pain in questions about PAS make it more acceptable in general. Hence, the research questions guiding this proposed research are:

- 1) In Winnipeg, is the general public in favour of PAS?
- 2) Does the general public indicate differences in acceptance of PAS for those who are 80 years old compared to those who are 40 years old?

- 3) Does the general public indicate differences in acceptance of PAS for those who are in pain and are 80 years old compared to those who are 40 years old?
- 4) What is the relationship between select socio-demographic characteristics and the acceptance of PAS? Specifically, age, education, gender, health status, and religion will be considered.

### **Summary**

The current debate concerning physician-assisted suicide provides an opportunity to investigate possible ageist opinions in a representative population of Canadians. Older Canadians are believed to be one group that could be at risk because of ageist opinions should the legislation guiding PAS be changed. There is a great deal of debate in the literature about the slippery slope and the danger that it poses to vulnerable persons in society. There has been little research to date on the effect of ageist opinions in Canada. Chapter Three will describe the methodology of this research.

## CHAPTER THREE: METHODOLOGY

### Introduction

The chapter begins by providing information about the Winnipeg Area Study (WAS) obtained from *The 2000 Winnipeg Area Study Sample Report* (Lewis, 2000), which includes a description of the data collection and sampling design. This is followed by a discussion of the variables that were measured and an outline of the data analysis for each research question.

### Sampling Design

The 2000 WAS used a population universe of all City of Winnipeg working telephone numbers. These numbers were gathered from The Manitoba Telephone System's "Who Called Me" directory for Winnipeg and were stored electronically (Lewis, 2000). A program developed by N.M. Lalu at the University of Alberta was used to generate a random sample of telephone numbers.

The primary sampling unit was the household. The selection criteria used to choose a respondent in each household was gender, age, and residence in the household. An eligible respondent had to reside at the address and be 18 years of age or older. Each home was randomly predesignated as male or female. The interviewers were instructed that if the person who answered the phone was not of the gender specified they were to ask the person to choose one in the household who was of the specified gender (see appendix B for interviewer instructions).

## Data Collection

The data for this study were obtained from the Winnipeg Area Study (2000), which is approved by the Psychology and Sociology Ethics Review Board (PSRB) prior to administration of the survey. The WAS is an annual, telephone survey done by the Sociology department at the University of Manitoba and is based on a random sample of 750 Winnipeg, Manitoba residents aged 18 and over. The WAS uses questions from multiple researchers on a variety of topics. The topic of this study in the WAS was Public Attitudes toward Euthanasia and the questions were numbered 28 to 41 and 47 (see appendix A for questions). Funding for these questions was received from a grant to B. Payne from the office of the vice-president, Research, University of Manitoba.

There were sixteen professional interviewers hired to administer the survey (see appendix B for interviewer's instructions). All interviewers were required to sign a contract ensuring confidentiality and to be present at two training sessions. The interviews began by informing respondents that all information was confidential and that they were free to refuse to answer any question they felt was too personal or inappropriate. All identifying names, phone numbers, and addresses were removed from the data file.

Interviewers were instructed to try a phone number a minimum of 10 times before it could be considered a non-contact. There were 359 no contact telephone numbers. In 159 cases respondents were replaced because of language, age, functionally impaired elder, poor health, or other reasons such as a death in the family. The completion rate was 71.0 percent of eligible households and interviews were conducted for 750 homes with a total of 306 refusals. Interviews had a mean length of 26 minutes.

### Measurement of Key Variables

There are two concepts of central significance in this study. The first is ageism and the second is PAS. Ageism and opinions about PAS were measured by employing a split-half design in which two versions of the survey were administered. The interviewers were given an equal number of each version and were instructed that they were to complete an equal number of Version A and an equal number of Version B. There were no other instructions provided about the ordering of the versions. The purpose of the split-half design was to determine whether acceptability of PAS for those having an incurable illness differed on the basis of age, i.e., whether the patient was 80 or 40 years old (question numbered 28, Appendix A).

Still employing the split-half design, respondents were asked a second time whether the acceptability of PAS for those suffering unbearable pain from an incurable illness differed on the basis of age, i.e., whether the patient was 80 or 40 years old (question numbered 33, Appendix A).

All other questions were the same in both versions including a question about the acceptability of PAS in Canada (question numbered 38, Appendix A). This question was included in order to ascertain the degree of acceptance of PAS without referring to age. Respondents were then asked to self-rate their health, i.e., whether it was poor, fair, good, very good, or excellent (question numbered 41, Appendix A).

Palmore's *Facts on Aging Quiz* was also administered to all respondents (Palmore, 1977). Three minor modifications were made to identify the population as Canadian and to update the year in one question to 2020 (question numbered 47s, 47y, and 47z,

Appendix A). According to Palmore (1981), this 26 item, true-false scale has many uses including: stimulating group discussion; measuring overall levels of information about aging; identifying most frequent misconceptions about aging; and providing an indirect measure of bias toward the aged (Palmore, 1977). The fourth use, measuring bias toward the aged is of primary interest for this study. Palmore claimed that sixteen items would indicate a negative bias and five items would indicate a positive bias if marked incorrectly (Palmore, 1977). The items that indicate a negative bias are numbered 1, 3, 5, 7, 8, 9, 10, 11, 13, 16, 17, 18, 21, 22, 24, and 25. The items that indicate a positive bias are 2, 4, 6, 12, and 14. To compute a net anti-aged or pro-aged score the percentage of errors on the negative bias items are subtracted from the percentage of errors on the positive bias items. The resulting score, if negative indicates a net anti-aged bias or if positive, indicates a pro-aged bias. Palmore quiz scores were collapsed into two categories, "pro-aged" and "anti-aged" for the purpose of analysis.

Socio-demographic information collected included gender, age, income, education, and religion. Gender was coded dichotomously as 1 for male and 2 for female. Age was reported in years and in this analysis was collapsed into the six categories: 18 to 24, 25 to 34, 35 to 44, 45 to 54, 55 to 64, and 65 and older. Income, reported in 31 categories, was collapsed into four categories for the purpose of analysis: under 20,000, 20,000 to 39,999, 40,000 to 59,999, 60,000 and over.

The 15 education categories were collapsed into three categories for analysis: Junior High or less, High School and other non-university, and some university. Religion was originally reported in 20 categories and it was also collapsed due to small numbers in many of the categories. The categories used in the analysis are Catholic, Protestant, No

Preference, and Other. All Protestant denominations were combined as were all Catholic denominations. Respondents who choose No Preference were left originally as reported. The Other category included all other denominations including those who choose the Christian unspecified.

### **Data Analysis**

The SPSS Version 13 for Windows was used for data analysis (SPSS Graduate Pack 13 for Windows, 2004 SPSS Inc.). Data analysis was undertaken using univariate, bivariate, and multivariate analysis. Univariate analysis included frequency distributions for the whole sample and where appropriate, for the two versions. Bivariate analysis of categorical variables used cross-tabulations with chi-square statistics. Cramer's V was used as a measure of association to interpret of the strength of the relationship between the variables (Munro, 2005). Variables found to be significant at the bivariate level were retained for multivariate analysis using multinomial logistic regression to describe the relationship between the predictor and dependent variables (Munro, 2005).

### **Summary**

This chapter has provided information about the Winnipeg Area Study including a description of the sampling design and data collection. This was followed by a description of the study variables and an outline of the data analysis. Chapter Four describes the sample characteristics.

## CHAPTER FOUR: SAMPLE CHARACTERISTICS

### Introduction

This chapter begins with a presentation of the sample characteristics that includes the variables, gender, age, income, education, religion, self-reported health status, and Palmore's Quiz scores. A comparison of the sample characteristics to Canadian Census data is then undertaken to assess the representativeness of the sample.

### Sample Characteristics

Of the 750 Winnipeggers who participated in the 2000 WAS the majority (57.2%) were female (Table 4.1). This pattern was consistent for both versions of the questionnaire as females predominated with 56.6% in Version A and 57.8% in Version B. Chi-square analysis confirms that the differences between the two versions are not significant for gender ( $\chi^2 = .121$ ; ns).

In comparison to the Canadian Census data for Winnipeg, (Statistics Canada, 2001), the proportion of females in the WAS was slightly higher (57.2%) than the Census (52%). A precise comparison was not possible between WAS and Census data as the age categories are not comparable.

**Table 4.1: Sample Characteristics**

	All(N=750) %	Version A (N=366) %	Version B (N=384) %
Male	42.8	43.4	42.2
Female	57.2	56.6	57.8
$x^2 = .121, p = .768, \text{Cramer's } V = .013$			
<b>Age</b>			
18-24	13.2	14.9	14.1
25-34	20.2	18.1	19.1
35-44	21.3	23.7	22.5
45-54	19.9	20.5	20.1
55-64	9.8	8.0	8.9
65+	15.4	14.9	15.2
$x^2 = 2.017, p = .847, \text{Cramer's } V = .052$			
<b>Income</b>			
Under 20,000	24.9	23.8	26.0
20,000-39,999	23.6	22.5	25.0
40,000-59,999	12.4	13.9	10.9
60,000+	39.1	40.2	38.0
$x^2 = 4.993, p = .172, \text{Cramer's } V = .082$			
<b>Religion</b>			
Protestant	30.2	30.4	30.0
Catholic	27.5	27.9	27.1
No Preference	26.5	26.5	26.5
Other	15.8	15.3	16.4
$x^2 = .171, p = .982, \text{Cramer's } V = .015$			
<b>Education</b>			
Junior High or less	4.6	5.2	4.0
High School, other non-university	58.5	58.5	58.6
Some University	36.9	36.3	37.5
$x^2 = .685, p = .710, \text{Cramer's } V = .030$			
<b>Ratings of Health</b>			
Fair/Poor	11.4	11.5	11.2
Good	25.9	25.0	26.7
Very Good	40.0	38.7	41.3
Excellent	22.8	24.7	20.9
$x^2 = 1.731, p = .630, \text{Cramer's } V = .048$			
<b>Palmore Quiz Scores</b>			
Pro-aged	47	48.4	47.7
Anti-aged	53	51.6	51.6
$x^2 = .156, p = .715, \text{Cramer's } V = .014$			

With Respect to age, values ranged from 18 to 96 years with a mean age of 43.88. The majority of respondents were in the 25 to 54 age group (61.8%) and the largest age concentration was the 35 to 44 group (22.5%) (Table 4.1). Version A also shows a similar distribution with the majority of respondents (61.4%) in the 25 to 54 age group and the largest age category was the 35 to 44 group (21.3%). In Version B the proportion of respondents in the 25 to 54 range is slightly higher (62.3%) and the largest age group was the 35 to 44 group (23.7%). Chi-square confirms that survey version and age of respondent are independent of each other ( $\chi^2 = 2.017$ ; ns).

In comparison to 2001 Census data for Winnipeg, the proportion of individuals in the WAS aged 18 to 64 (84.8%) was higher than those age 20 to 64 in the Census (60.5%). In the 65 and older age category, the WAS (15.4 %) was similar to the 2001 Census data for Winnipeg (13.7%). A precise comparison was not possible because the Census and WAS age categories are not comparable.

With respect to income, the majority of respondents (34.8%) were in the \$20,000 to \$39,999 category (Table 4.1). Version A shows a similar distribution (32.9%), as does Version B, which has a slightly larger (36.6%) proportion of respondents in the \$20,000 to \$39,999 category. Chi-square indicates that the differences between the survey versions are not significant for income ( $\chi^2 = 4.993$ ; ns).

It was not possible to compare income data from the 2000 WAS to Canadian Census data for 2001 as the income categories were not comparable. The 2000 WAS was compared to previous WAS samples and found to have small differences in some categories. For example, the 2000 WAS had the lowest percentages of respondents in the under \$20,000 categories and the highest percentage in the over \$40,000 of the last five

years (Lewis, 2000). The 2000 WAS had the largest non-response group (N=242) of any prior WAS samples resulting in a response rate of 67.7 percent for this question (Lewis, 2000).

With respect to religion, the majority of respondents (30.2%) (Table 4.1) were in the Protestant Category. Version A (30.4%) and Version B (30.0%) also show a similar distribution with the majority in the Protestant category. The minority of respondents (15.8%) were in the Other category. Version A (15.3%) and Version B (16.4%) also show a similar distribution with the minority in the Other category. Chi-square confirms that the differences between survey version are not significant for religion ( $\chi^2 = .171$ ).

The 2001 Canadian Census data on religion for Winnipeg show a similar distribution to the WAS. The Census reported a majority (34.2%) in the Protestant category compared to 30.2% WAS. The Census also shows a slightly higher distribution for Catholic (32.6% versus 27.5 for WAS), and for the Other category, a slightly lower distribution (12.5% to 15.8%). The WAS reports a larger group of respondents (26.5%) in the No Preference category than the Census (20.7%).

With respect to education, the majority (58.5%) reported having High School or non-university (Table 4.1). This is similar to the distribution of respondents for this question in Version A (58.5%) and Version B (58.6%). Junior High or less was the smallest category (4.6%) for the whole sample and was similar for both Version A (5.2%) and Version B (4.0%). For the sample as a whole, the category "Some University" was a little more than a third of the respondents (36.9%). It was similarly distributed for Version A (36.3%) and for Version B (37.5%). Chi-square confirms that education and survey version are not related to each other ( $\chi^2 = .685$ ; ns).

In comparison to the 2001 Canadian Census for Winnipeg, the WAS Sample has a much smaller (4.6%) group of respondents than the Census (22.8%) in the “Junior High or less” category. For the WAS, the High School and other non-university had the largest number of respondents (58.5%), which was similar to the Census (53.5%). The third category, “Some University”, was larger in the WAS sample (36.9%) than the Census (23.7%). The categories used in the Census are different than the WAS in that the Census uses a “University” category rather than “Some University”, as in the WAS. Another difference is that the Census uses respondents aged 25 to 64 rather than aged 18 and over as does the WAS.

In examining self-rated health status, the majority of respondents (40%) (Table 4.1) rated themselves as Very Good. There was a similar distribution for this category in Version A (38.7%) and in Version B (41.3%). Only one tenth of respondents in the whole sample rated themselves as Poor or Fair (11.4), which was similar to respondents in Version A (11.5) and Version B (11.2). The Canadian Census or WAS did not have comparable data available for this self-rated health question. Chi-square analysis indicated that self-rated health status and survey version were independent of each other ( $\chi^2 = 1.731$ ; ns).

With respect to Palmore’s Quiz Scores, a small majority of the respondents (52.3%) were in the “anti-aged” category (Table 4.1). There was a similar distribution for Version A and for Version B. Chi-square indicates that Palmore’s Quiz Scores and survey version are independent of each other ( $\chi^2 = .156$ ; ns).

### **Representativeness of the Sample**

Comparisons between the 2000 WAS have been made to the 2001 Canadian Census data and the WAS was found to be similar to the Census in age, gender, and religion. It was slightly different but similar to the Census in education. A comparison was not possible for income, self-rated health status, and Palmore's Quiz Scores.

According to *The 2000 Winnipeg Area Study Sample Report* the sample was compared to the 1996 Canadian Census data to assess its representativeness. When appropriate comparisons between the WAS data and Canadian Census data were not possible, previous WAS samples were used. The 2000 WAS was found to be similar to the 1996 Canadian Census in terms of gender, age, and ownership of dwelling. It was comparable to previous WAS samples in terms of gender, age, education, paid work situations, household size, household income, selected residence characteristics, and ownership of dwelling (Lewis, 2000).

Given the small differences between the WAS sample and the 1996 and 2001 census data for Winnipeg, it is concluded that the WAS sample is representative of the general population and that the findings of the survey can be generalized to the population at large of Winnipeg.

### **Summary**

The chapter provided information about the Winnipeg Area Study, which included a description of the data collection and sampling design. It also included a discussion of the representativeness of the sample to the Winnipeg population. Although a complete comparison to Census data was not possible, it was concluded that the 2000 WAS sample

was representative of the Winnipeg population. As well, no statistical significance was found between Version A and Version B for all of the variables. Chapter Five will discuss the results of the analysis.

## CHAPTER FIVE: RESULTS

### Introduction

In this chapter the results are presented for the three dependent variables of interest in this study including: public opinion on the legalization of mercy killing; acceptance of PAS; and acceptance of PAS for those who are in pain. Results are presented for univariate, bivariate, and multivariate findings.

### Legalization of Mercy Killing

The majority of the 719 respondents who answered this question (60.6%) agreed or strongly agreed that Canada should have a similar law to the Netherlands (Table 5.1). Only 11.1 percent of respondents were neutral about the issue. A minority of respondents (28.2%) disagreed or strongly disagreed with legalizing mercy killing in Canada.

Table 5.1: Agreement with Legalizing Mercy Killing

	Frequency	Valid Percent
STRONGLY DISAGREE	98	13.6
DISAGREE	105	14.6
NEITHER AGREE NOR DISAGREE	80	11.1
AGREE	298	41.4
STRONGLY AGREE	138	19.2
Total	719	100.0

When examining public opinion on the legalization of mercy killing by sociodemographic measures, statistically significant differences were found for the

**Table 5.2: Agreement with Legalization of Mercy Killing by Socio-demographic Variables**

	Legalize Mercy Killing				
	Strongly Disagree %	Disagree %	Neither Agree Nor Disagree %	Agree %	Strongly Agree %
Male (n=301)	11.9	13.2	9.4	45.8	19.7
Female (n=429)	14.9	15.6	12.5	38.1	18.8
$\chi^2 = 5.960, p = .202, \text{Cramer's } V = .091$					
<b>Age</b>					
18-24 (n=103)	8.9	12.9	19.8	44.6	13.9
25-34 (n=140)	7.3	15.3	10.2	45.3	21.9
35-44 (n=165)	11.3	13.2	11.9	42.1	21.4
45-54 (n=148)	18.2	9.1	9.8	37.1	25.9
55-64 (n=65)	20.6	20.6	6.3	38.1	14.3
65+ (n=111)	17.2	22.2	9.1	40.4	11.1
$\chi^2 = 40.956, p = .004, \text{Cramer's } V = .121$					
<b>Income</b>					
<\$20,000 (n=187)	16.5	16.5	9.4	38.8	18.8
\$20,000-\$39,999(n=177)	11.5	18.4	10.9	42.5	16.7
\$40,000-\$59,999(n=93)	11.6	10.5	9.3	46.5	22.1
>\$60,000 (n=293)	13.8	12.5	12.8	40.8	20.1
$\chi^2 = 9.303, p = .677, \text{Cramer's } V = .066$					
<b>Religion</b>					
Protestant(n=221)	14.7	15.6	9.0	38.4	22.3
Catholic (n=201)	17.5	15.5	13.4	43.8	9.8
No Preference(n=194)	4.8	7.4	12.2	47.3	28.2
Other (n=116)	16.8	23.0	8.8	35.4	15.9
$\chi^2 = 50.742, p = .000, \text{Cramer's } V = .155$					
<b>Education</b>					
Junior High Or Less (n=34)	22.6	22.6	3.2	29.0	22.6
High School, Other Non-University (n=436)	12.4	12.9	11.2	42.7	20.8
Some University(n=275)	13.6	16.3	11.7	41.7	16.7
$\chi^2 = 9.713, p = .286, \text{Cramer's } V = .082$					
<b>Ratings of Health</b>					
Fair/Poor (n=84)	16.5	15.2	7.6	40.5	20.3
Good (n=192)	15.0	19.4	12.2	34.4	18.9
Very Good(n=297)	12.7	13.4	9.2	46.6	18.2
Excellent (n=169)	12.3	11.1	14.2	40.7	21.6
$\chi^2 = 13.804, p = .313, \text{Cramer's } V = .313$					
<b>Palmore Quiz Scores</b>					
Pro-aged	10.4	13.9	13.6	42.3	19.8
Anti-aged	16.6	15.2	8.8	40.6	18.7
$\chi^2 = 9.114, p = .058, \text{Cramer's } V = .113$					

variables of religion and age of respondent (Table 5.2). However, further analyses to test the strength of the relationships showed that their relationships were weak.

Although males (65.5%) were more likely than females (56.9%) to agree or strongly agree with legalizing mercy killing ( $p = .202$ ) this difference was not statistically significant (Table 5.2).

In examining age differences, the majority of respondents agreed with legalizing mercy killing with less than one fifth expressing a neutral stance. Those in the 45 to 54 age group were the most likely to strongly agree (25.9%) but the majority of responses fell into the “agree category” (Table 5.2). Respondents aged 25 to 34 were the most likely to agree (45.3%) to mercy killing with only small variations for those in the other age groups (18 to 24 (44.6%); 35 to 44 (42.1%); 45 to 54 (37.1%); 55 to 64 (38.1%); and 65+ (40.4)). The relationship between age of respondent and attitudes toward mercy killing was statistically significant at the .01 level ( $p = .004$ ) but the relationship was weak (Cramer’s  $V = .121$ ).

The majority of respondents in all income groups agreed with the legalization of mercy killing (Table 5.2). The relationship between income and attitudes toward mercy killing was not significant at the ( $p = .677$ ).

The majority of respondents in all religious groups agreed with the legalization of mercy killing. Those in the No Preference group were the most likely to agree (47.3%) (Table 5.2). Those in the Catholic group were least likely (9.8%) to strongly agree and those in the no preference group were least likely (4.8%) to strongly disagree. The relationship between religion and the legalization of mercy killing was statistically significant at the .01 level ( $p = .000$ ) but the relationship was weak (Cramer’s  $V = .155$ ).

With respect to education level attained, the majority of respondents agreed with the legalization of mercy killing. Those with high school or other non-university (42.7%) and those with some university (41.7%) fell into the agree category (Table 5.2). However, those with junior high or less were the most likely to disagree (22.6%) or strongly agree (22.6%) and expressed a neutral stance the least often (3.2%) of all groups. The relationship between education and attitudes toward the legalization of mercy killing was not significant ( $p = .286$ ).

In examining self-reported health ratings the majority of respondents agreed with the legalization of mercy killing. Those who reported their health as very good had the most respondents agree (46.6%) (Table 5.2). The relationship between self-reported ratings of health and legalization of mercy killing was not significant ( $p = .313$ ).

With respect to Palmore's Quiz Scores, respondents in the pro-aged and anti-aged groups were similar in distribution for all categories. The majority of respondents agreed with the legalization of mercy killing (Table 5.2). Respondents in the pro-aged group were more likely to be neutral (13.6% versus 8.8% for the anti-aged), to agree or strongly agree (62% versus 59.3% for the anti-aged) and the least likely (10.4% versus 16.6% for the anti-aged) to strongly disagree with the legalization of mercy killing. The relationship between Palmore Quiz Scores and legalization of mercy killing was not significant ( $p = .058$ ).

This section has examined the relationship between socio-demographic variables and attitudes toward mercy killing. The socio-demographic variables of religion and age of respondent were found to be statistically significant but weakly related.

### Acceptance of PAS

The majority of the 718 respondents who answered this question (61.5%) agreed or strongly agreed that if a person is suffering because of an incurable illness and wishes to die that PAS is acceptable (Table 5.3).

TABLE 5.3: Acceptance of PAS

	Frequency	Valid Percent
STRONGLY DISAGREE	88	12.3
DISAGREE	105	14.6
NEITHER AGREE NOR DISAGREE	83	11.6
AGREE	278	38.7
STRONGLY AGREE	164	22.8
Total	718	100.0

Only 11.6 percent of respondents were neutral about the issue. A minority of respondents (26.9%) disagreed or strongly disagreed with the acceptability of PAS.

When examining public opinion on the acceptability of PAS based on survey version the majority of respondents in Version A (80 years) (65.3%) and in Version B (40 years) (58%) agreed or strongly agreed that PAS is acceptable (Table 5.4).

Table 5.4: Acceptance of PAS by Survey Version

	SURVEY VERSION	
	VERSION A	VERSION B
STRONGLY DISAGREE	10.5%	14.0%
DISAGREE	13.8%	15.4%
NEITHER AGREE NOR DISAGREE	10.5%	12.6%
AGREE	37.9%	39.6%
STRONGLY AGREE	27.4%	18.4%
	100.0%	100.0%

Only 10.5 percent of respondents in Version A and 12.6 percent of respondents in Version B were neutral about the issue. A minority of respondents (24.3%) in Version A and (29.4%) in Version B disagreed or strongly disagreed with the acceptance of PAS. The relationship between acceptability of PAS and survey version was approaching statistical significance at the .05 level ( $p = .052$ ).

When examining public opinion of the acceptability of PAS by sociodemographic measures, statistically significant differences were found for the variables of gender, age, and religion. However, further analyses to test the strength of the relationships showed that the relationships were weak. The bivariate tables illustrating relationships between acceptance of PAS and the socio-demographic variables by survey version can be found in Appendix C, Table C.1).

Males (68.3%) were more likely than females (56.3%) to agree or strongly agree with the acceptance of PAS (Table 5.5). The relationship between acceptance of PAS and gender was significant at the .05 level ( $p = .028$ ) but the relationship was weak (Cramer's  $V = .123$ ).

Table 5.5: Acceptance of PAS &amp; Socio-demographic Variables

	Acceptance of PAS				
	Strongly Disagree %	Disagree %	Neither Agree Nor Disagree %	Agree %	Strongly Agree %
Male (n=310)	10.3	11.9	9.4	43.5	24.8
Female (n=408)	13.7	16.7	13.2	35.0	21.3
$\chi^2 = 10.895, p = .028, \text{Cramer's } V = .123$					
<b>Age</b>					
18-24 (n=101)	3.0	16.8	12.9	41.6	25.7
25-34 (n=136)	6.6	13.2	13.2	44.9	22.1
35-44 (n=158)	10.8	16.5	10.8	39.2	22.8
45-54 (n=140)	17.1	7.1	10.7	37.9	27.1
55-64 (n=63)	12.7	22.2	9.5	31.7	23.8
65+ (n=103)	22.3	17.5	10.7	34.0	15.5
$\chi^2 = 39.736, p = .005, \text{Cramer's } V = .119$					
<b>Income</b>					
<\$20,000 (n=183)	8.7	18.6	12.6	35.5	24.6
\$20,000-\$39,999 (n=171)	7.6	12.3	11.7	41.5	26.9
\$40,000-\$59,999 (n=89)	14.6	7.9	12.4	38.2	27.0
>\$60,000 (n=275)	16.7	15.6	10.5	39.3	17.8
$\chi^2 = 15.861, p = .198, \text{Cramer's } V = .086$					
<b>Religion</b>					
Protestant (n=211)	14.2	14.7	11.4	34.1	25.6
Catholic (n=193)	16.1	17.1	12.4	38.9	15.5
No Preference (n=188)	3.2	6.4	11.7	48.9	29.8
Other (n=112)	15.2	22.3	10.7	30.4	21.4
$\chi^2 = 48.477, p = .000, \text{Cramer's } V = .152$					
<b>Education</b>					
Junior High Or Less (n=33)	15.2	15.2	9.1	33.3	27.3
High School, Other Non-University (n=420)	11.4	14.0	8.8	42.1	23.6
Some University (n=260)	12.3	15.4	16.2	34.6	21.5
$\chi^2 = 11.498, p = .175, \text{Cramer's } V = .090$					
<b>Ratings of Health</b>					
Fair/Poor (n=81)	16.0	13.6	8.6	39.5	22.2
Good (n=176)	14.8	15.9	10.8	36.9	21.6
Very Good (n=292)	9.2	16.1	11.0	39.7	24.0
Excellent (n=163)	12.9	10.4	15.3	38.8	22.7
$\chi^2 = 10.043, p = .612, \text{Cramer's } V = .069$					
<b>Palmore Quiz Scores</b>					
Pro-aged (n=346)	9.0	16.8	11.0	40.8	22.5
Anti-aged (n=372)	15.3	12.6	12.1	36.8	23.1
$\chi^2 = 8.943, p = .063, \text{Cramer's } V = .112$					

With respect to age differences, the majority of respondents in the 25 to 34 age group were most likely to agree (44.9%) with the acceptance of PAS (Table 5.5). Respondents in the disagree group were in the majority if they were aged 55 to 64 (22.2%) and in the minority if they were aged 45 to 54 group (7.1%). The relationship between acceptance of PAS and age of respondent was statistically significant at the .01 level ( $p = .005$ ) but the relationship was weak (Cramer's  $V = .119$ ).

In examining income, the majority of respondents in all groups agreed with the acceptance of PAS (Table 5.5). The relationship between income and attitudes toward the acceptability of PAS was not significant ( $p = .198$ ).

With respect to religious differences, the majority of respondents in all categories agreed with the acceptance of PAS (Table 5.5). Those in the No Preference group were the most likely to agree (48.9%) and least likely to disagree (6.4%) or strongly disagree (3.2%). The relationship between religious differences and attitudes toward the acceptance of PAS was statistically significant at the .01 level ( $p = .000$ ) but the relationship was weak (Cramer's  $V = .152$ ).

For education level attained, the majority of respondents in all categories agreed with the acceptance of PAS. Those with high school, or other non-university (42.1%) and those with some university (34.6%) fell into the agree category (Table 5.5). The relationship between education and attitudes toward the acceptance of PAS was not significant ( $p = .175$ ).

In examining self-reported health ratings the majority of respondents agreed with the legalization of mercy killing. Those who reported their health as very good had the most respondents agree with the acceptance of PAS (39.7%) (Table 5.5). The relationship

between self-reported ratings of health and the acceptance of PAS was not statistically significant ( $p = .612$ ).

With respect to Palmore's Quiz Scores, the majority of respondents in both categories agreed with the acceptance of PAS (Table 5.5). Respondents who scored in the pro-aged group were the least likely (9%) to strongly disagree with legalizing mercy killing. The relationship between Palmore's Quiz Scores and the acceptance of PAS was not significant ( $p \text{ value} = .063$ ).

This section has presented data examining the relationship between socio-demographic variables and attitudes toward the acceptance of PAS. The socio-demographic variables of gender, age, and religion were found to be statistically significant but weakly related to the acceptance of PAS. The variable of survey version or age of the target person was not found to be statistically significant.

### **Acceptance of PAS: Multivariate Analysis**

To better understand the relationship between the predictor variables and the acceptance of PAS, multinomial logistic regression was undertaken (Munro, 2005). The criterion for inclusion of a variable in a regression equation was significance at the .05 level in bivariate analysis with the acceptance of PAS. The predictor variables included in the model were gender, age, and religion.

Prior to performing the logistic regression a test for multicollinearity was conducted and no collinearity was found among the independent variables. Tests for collinearity from the linear regression option were used to produce collinearity diagnostics (Field, 2003) (Table 5.6).

**Table 5.6: Collinearity Statistics for the Acceptance of PAS**

<u>Model</u>	<u>Tolerance</u>
Gender	.992
Age	.919
<u>Religion</u>	<u>.915</u>

According to Menard (1995) a tolerance value less than 0.1 suggests a problem with collinearity. The tolerance values are all higher than 0.1 which suggests that multicollinearity is not a problem in this analysis.

As shown in Table 5.7, the 2LL value (1539.801) indicated that the independent variables provided a low level of explanation for the acceptance of PAS. The model chi-square was 85.422 which was significant ( $p = .000$ ), indicating that the model did outperform the null hypothesis. The variance in the acceptance of PAS that was accounted for ranged from 11.7% (Cox and Snell) to 12.3% (Nagelkerke) (Munro, 2005).

The likelihood ratio indicated that the variables of age, gender, and religion made contributions to the model. The variable of religion ( $p = .000$ ) was found to be very significant to acceptance of PAS (Table 5.7). Age ( $p = .000$ ), and gender ( $p = .041$ ) were also significant predictors for the acceptance of PAS.

The odds of respondents strongly agreeing with the acceptance of PAS were less for older (OR= .968, 95% CI= .952; .984) rather than younger respondents. Males were more likely to agree (OR= 1.506, 95% CI= .887; 2.558) with the acceptance of PAS than females. Respondents in the No Preference group were more likely to agree (OR= 8.173, 95% CI= 2.916; 22.905) and strongly agree (OR= 7.016, 95% CI= 2.412; 20.411) about the acceptance of PAS.

**Table 5.7: Multivariate Analysis of PAS<sup>1</sup>**

	Strongly Agree		Agree		Neutral		Disagree	
	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper
<b>Gender<sup>2</sup></b> p= .041	1.364	.775/2.402	1.498	.883/2.542	.837	.434/1.616	.815	.440/1.511
<b>Age<sup>3</sup></b> p= .000	.968	.953/.984	.968	.954/.982	.967	.949/.985	.977	.960/.994
<b>Religion<sup>4</sup></b>								
Protestant	1.990	.868/4.563	1.946	.888/4.262	1.765	.666/4.685	.951	.404/2.237
Catholic	.826	.359/1.900	1.459	.686/3.102	1.220	.472/3.152	.800	.353/1.815
No Preference	7.047	2.431/20.428	8.126	2.902/22.751	5.184	1.582/16.984	1.375	.427/4.431
	p= .000							
	2LL = 1539.801, $\chi^2 = 85.422$ , p = .000							

1 The reference category is strongly disagree.

2 The reference category is female

3 The reference age is 96.

4 The reference category is other.

This section has examined the relationship between the predictor and outcome variables for the acceptance of PAS at the multivariate level. Those who were younger, male, and in the No Preference category for religion were more likely to strongly agree with the acceptance of PAS.

#### **Acceptance of PAS by Version: Multivariate Analysis**

When examining public opinion of the acceptability of PAS by sociodemographic measures for each version, statistically significant differences at the bivariate level varied according to the version (Appendix C: Table C.1). The variables of age and religion

were significant for Version A and the variable of religion was significant for Version B. Multinomial Logistic Regression was undertaken to better understand the relationship between the predictor variables and the acceptance of PAS in Version A. A variable was required to be significant in the bivariate analysis at the .05 level to be included in the regression equation. Prior to performing the logistic regression a test for multicollinearity was performed and collinearity was not found among the predictor variables (Table 5.8).

**Table 5.8: Collinearity Statistics for the Acceptance of PAS: Version A**

<u>Model</u>	<u>Tolerance</u>
Age	.935
Religion	.935

The tolerance values for all the variables are well above .1 suggesting that multicollinearity is not a problem in this analysis.

As shown in Table 5.9, the 2LL value for Version A (737.543) indicated that the predictor variables provided a low level of explanation for the acceptance of PAS. The model chi-square was 36.980 and was significant ( $p = .002$ ) indicating that the model did outperform the null hypothesis. The variance in the acceptance of PAS that was accounted for ranges from 10.3% (Cox and Snell) to 10.9% (Nagelkerke) (Munro, 2005).

For Version A, the likelihood ratio indicated that the variable of age ( $p = .007$ ) was statistically significant (Table 5.9). Religion was not statistically significant at the multivariate level ( $p = .060$ ). Respondents who were older were less likely to strongly

agree (OR=.958, 95% CI=.936;.981) and agree (OR=.967, 95% CI=.946;.989) with the acceptance of PAS in Version A.

**Table 5.9: Multivariate Analysis of PAS: Version A<sup>1</sup>**

	Strongly Agree		Agree		Neutral		Disagree	
	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper
<b>Age</b> p= .007	.958	.936/.981	.967	.946/.989	.961	.934/.989	.971	.946/.996
<b>Religion<sup>3</sup></b>								
Protestant	1.931	.591/6.304	1.371	.434/4.328	1.488	.364/6.093	1.237	.353/4.335
Catholic	1.461	.425/5.024	2.251	.703/7.210	1.402	.328/5.986	1.234	.339/4.499
No Preference	4.517	1.104/18.477	4.972	1.263/19.570	2.740	.541/13.867	.899	.174/4.644
p= .060								
2LL = 737.543, $\chi^2 = 36.980$ , p = .002								

1 The reference category is strongly disagree.

2 The reference age is 96.

3 The reference category is other.

For Version B, the -2LL value (106.300) indicated that the predictor variable religion provided a low level of explanation for the acceptance of PAS (Table 5.10). The model chi-square is 41.167, which was significant (p = .000) indicating that the model outperformed the null hypothesis. The variance in the acceptance of PAS that was accounted for is 10.9% to 11.5(Cox and Snell; Nagelkerke) (Munro, 2005). Respondents in Version B who were in the No Preference group for religion were more likely to agree (OR=14.627, 95% CI= 2.810; 76.145).

**Table 5.10: Multivariate Analysis of PAS: Version B<sup>1</sup>**

	<b>Strongly Agree</b>		<b>Agree</b>		<b>Neutral</b>		<b>Disagree</b>	
	OR	<u>95 CI</u>	OR	<u>95 CI</u>	OR	<u>95 CI</u>	OR	<u>95 CI</u>
	Lower/Upper		Lower/Upper		Lower/Upper		Lower/Upper	
<b>Religion<sup>2</sup></b>								
Protestant	1.785	.557/5.833	2.528	.859/7.441	2.036	.552/7.943	.736	.224/2.420
Catholic	.428	.128/1.432	.983	.357/2.707	1.183	.328/4.270	.582	.197/1.716
No Preference	11.579	2.094/64.015	14.627	2.810/76.145	11.025	1.745/69.671	2.394	.397/14.430
p= .000								
2LL = 106.300, $\chi^2 = 41.167$ , p = .000								

1 The reference category is strongly disagree.

2 The reference category is other.

This section has examined the relationship between the predictor and outcome variables by version at the multivariate level. Respondents in Version A were less likely to strongly agree with the acceptance of PAS if they were older. Religion was the only variable to be included in the model for Version B and respondents in the No Preference group were more likely to strongly agree and agree with the acceptance of PAS.

### **Acceptance of PAS with Unbearable Pain**

The majority of the 720 respondents who answered this question (67.8%) agreed or strongly agreed that if a person is suffering from unbearable pain because of an incurable illness and wishes to die that PAS is acceptable (Table 5.11). Only 8.6 percent of respondents were neutral about the issue. A minority of respondents (23.7%) disagreed or strongly disagreed with the acceptability of PAS for those in unbearable pain.

**Table 5.11: Acceptance of PAS with Unbearable Pain**

	Frequency	Valid Percent
STRONGLY DISAGREE	76	10.6
DISAGREE	94	13.1
NEITHER AGREE NOR DISAGREE	62	8.6
AGREE	317	44.0
STRONGLY AGREE	171	23.8
Total	720	100.0

When examining public opinion on the acceptability of PAS for those in unbearable pain based on survey version the majority of respondents in Version A (70.8%) and in Version B (64.8%) agreed or strongly agreed that PAS is acceptable for those in unbearable pain (Table 5.12). Only 6.7 percent of respondents in Version A and 10.4 percent of respondents in Version B were neutral about the issue. A minority of respondents in Version A (22.4%) and in Version B (24.8%) disagreed or strongly disagreed with the acceptance of PAS for those in unbearable pain. The relationship between acceptability of PAS for those in unbearable pain and survey version was not significant (chi-square  $p = .173$ ).

**TABLE 5.12: Acceptance of PAS with Unbearable Pain by Survey Version**

		SURVEY VERSION (%)		Total
		VERSION A	VERSION B	
UNBEARABLE PAIN 80 (40) YEAR OLD	STRONGLY DISAGREE	9.8	11.3	10.6%
	DISAGREE	12.6	13.5	13.1%
	NEITHER AGREE NOR DISAGREE	6.7	10.4	8.6%
	AGREE	43.8	44.2	44.0%
	STRONGLY AGREE	27.0	20.6	23.8%
Total		100.0	100.0	100.0%

When examining public opinion of the acceptability of PAS for those in unbearable pain by socio-demographic measures, statistically significant differences were found for

the variables of age and religion (Table 5.13). However, further analyses to test the strength of the relationships showed that the relationships were weak.

**Table 5.13: Acceptance of PAS with Unbearable Pain by Socio-demographic Variables**

	Acceptance of PAS				
	Strongly Disagree %	Disagree %	Neither Agree Nor Disagree %	Agree %	Strongly Agree %
Male (n=309)	9.1	12.9	5.8	47.2	24.9
Female (n=411)	11.7	13.1	10.7	41.6	22.9
$x^2 = 7.616, p = .107, \text{Cramer's } V = .103$					
<b>Age</b>					
18-24 (n=103)	2.0	15.7	9.8	45.1	27.5
25-34 (n=140)	6.7	11.9	6.7	49.6	25.2
35-44 (n=165)	10.2	10.8	9.6	45.2	24.2
45-54 (n=148)	14.9	7.1	9.2	42.6	26.2
55-64 (n=65)	12.5	15.6	10.9	39.1	21.9
65+ (n=111)	15.1	22.6	7.5	38.7	16.0
$x^2 = 34.506, p = .023, \text{Cramer's } V = .111$					
<b>Income</b>					
<\$20,000 (n=172)	12.8	17.4	6.4	40.1	23.3
\$20,000-\$39,999 (n=175)	11.4	12.6	10.3	44.6	21.1
\$40,000-\$59,999 (n=85)	11.8	12.9	4.7	47.1	23.5
>\$60,000 (n=288)	8.3	10.8	10.1	45.1	25.7
$x^2 = 11.745, p = .466, \text{Cramer's } V = .074$					
<b>Religion</b>					
Protestant (n=216)	12.5	15.3	7.4	40.7	24.1
Catholic (n=194)	13.9	12.1	11.3	43.8	18.6
No Preference (n=187)	3.7	4.8	8.0	52.4	31.0
Other (n=110)	11.8	22.7	7.3	36.4	21.8
$x^2 = 43.837, p = .000, \text{Cramer's } V = .144$					
<b>Education</b>					
Junior High Or Less (n=33)	15.2	12.1	9.1	33.3	30.3
High School, Other Non-University (n=420)	9.0	13.3	7.1	45.7	24.8
Some University (n=262)	11.8	12.2	10.7	43.5	21.8
$x^2 = 6.861, p = .552, \text{Cramer's } V = .069$					
<b>Ratings of Health</b>					
Fair/Poor (n=80)	7.5	15.0	3.8	50.0	23.8
Good (n=178)	12.9	15.2	10.7	38.8	22.5
Very Good (n=292)	8.6	13.7	7.9	45.5	24.3
Excellent (n=164)	12.2	9.1	10.4	43.9	24.4
$x^2 = 11.945, p = .450, \text{Cramer's } V = .450$					
<b>Palmore Quiz Scores</b>					
Pro-aged (n=349)	8.6	13.8	8.6	45.0	24.1
Anti-aged (n=371)	12.4	12.4	8.6	43.1	23.5
$x^2 = 2.887, p = .577, \text{Cramer's } V = .063$					

Males (72.1%) were more likely than females (64.5%) to agree or strongly agree with PAS for those in unbearable pain (Table 5.13). Females (10.7%) doubled males (5.8%) in the neutral category. The relationship between PAS for those in unbearable pain and gender was not significant ( $p = .107$ ).

With respect to age differences, the majority of respondents in all groups agreed with PAS for those in unbearable pain. Respondents in the 25 to 34 age group were most likely to agree (49.6%) and in the 45 to 54 age group were least likely to disagree (7.1%) with the acceptability of PAS for those in unbearable pain (Table 5.13). The relationship between PAS for those in unbearable pain and age of respondent was statistically significant at the .05 level ( $p = .023$ ) but the relationship was weak (Cramer's  $V = .111$ ).

In regard to income, the majority of respondents in all groups agreed with the acceptance of PAS for those in unbearable pain (Table 5.13). Respondents with an income of \$40,000 to \$59,999 were most likely to agree (47.1%). The relationship between income and attitudes toward the acceptability of PAS for those in unbearable pain was not statistically significant ( $p = .466$ ).

In examining religious differences, the majority of respondents agreed with the acceptance of PAS for those in unbearable pain (Table 5.13). Those in the No Preference group were the most likely to agree and strongly agree (83.4%) and least likely to strongly disagree or disagree (8.5%). The relationship between religious differences and attitudes toward the acceptance of PAS for those in unbearable pain was statistically significant ( $p = .000$ ) but the relationship was weak (Cramer's  $V = .144$ ).

With respect to education level attained, the majority of respondents agreed with the acceptance of PAS for those in unbearable pain. Those with high school or other non-

university (70.5%) were most likely to agree or strongly agree (Table 5.13). The relationship between education and attitudes toward the acceptance of PAS for those in unbearable pain was not significant ( $p = .552$ ).

In examining self-reported health ratings the majority of respondents in all categories agreed with the acceptance of PAS for those in unbearable pain (Table 5.13). Those who reported their health as fair or poor were the most likely to agree (50.0%) with the acceptance of PAS for those in unbearable pain. The relationship between self-reported ratings of health and acceptance of PAS for those in unbearable pain was not significant ( $p = .450$ ).

With respect to Palmore's Quiz Scores, respondents who scored in the pro-aged groups were the most likely (45.0%) to agree with the acceptance of PAS for those in unbearable pain (Table 5.13). The relationship between Palmore's Quiz Scores and acceptance of PAS for those in unbearable pain was not significant ( $p = .577$ ).

This section has presented the relationship between socio-demographic variables and attitudes toward the acceptance of PAS for those in unbearable pain. The socio-demographic variables of age and religion were found to be statistically significant though weakly related to the acceptance of PAS for those in unbearable pain. The variable of version was not statistically significant.

### **Acceptance of PAS with Unbearable Pain: Multivariate Analysis**

Logistic regression was performed to better understand the relationship between the predictor variables and the acceptance of PAS for those in unbearable pain. The criterion for inclusion of a variable in a regression equation was being significant at the .05 level

in bivariate analysis with the variable of outcome. The predictor variables that were analyzed using logistic regression were age and religion.

Prior to the regression a test for multicollinearity was performed and collinearity was not found among the independent variables as the tolerance values for all the variables are well above .1 (Table 5.14).

**Table 5.14: Collinearity Statistics for the Acceptance of PAS with Unbearable Pain**

<u>Model</u>	<u>Tolerance</u>
Age	.916
Religion	.916

In the multivariate analysis, the -2LL value (1263.72) indicated that the independent variables provided a low level of explanation for the acceptance of PAS (Table 5.15). The model chi-square of 71.04 was significant ( $\chi^2 = .000$ ) and indicated that the model did outperform the null hypothesis. The variance in the acceptance of PAS that was accounted for ranges from 9.7% (Cox and Snell) to 10.4% (Nagelkerke) (Munro, 2005).

The likelihood ratio indicated that the variables of religion ( $p = .000$ ) and age ( $p = .017$ ) contributed significantly to the model. Respondents who are older were less likely to strongly agree (OR=.975, 95% CI=.959; .991) and agree (OR=.977, 95% CI=.962; .992) with the acceptance of PAS for those in unbearable pain (Table 5.15).

**Table 5.15: Multivariate Analysis of PAS and Unbearable Pain<sup>1</sup>**

	Strongly Agree		Agree		Neutral		Disagree	
	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper
<b>Age<sup>2</sup></b> p= .017	.975	.959/1.991	.977	.962/1.992	.978	.958/1.997	.988	.977/1.012
<b>Religion<sup>3</sup></b>								
Protestant	1.393	.578/3.357	1.413	.624/1.992	1.286	.958/1.997	.666	.270/1.640
Catholic	.800	.334/1.913	1.083	.489/2.399	1.483	.508/4.333	.444	.181/1.089
No Preference	4.494	1.586/13.879	4.480	1.635/12.277	3.457	.969/12.332	.629	.188/2.100
p= .000								
2LL = 1263.72, $\chi^2 = 71.04$ , p= .000								

<sup>1</sup> The reference category is strongly disagree.

<sup>2</sup>The reference age is 96.

<sup>3</sup> The reference category is other.

The No Preference group were more likely to strongly agree (OR=4.494, 95% CI=1.568; 12.879) and agree (OR = 4.480, 95% CI = 1.635; 12.277) than other categories for religion about the acceptance of PAS for those in unbearable pain.

This section has examined at the relationship between the predictor and outcome variables at the multivariate level. The variables of age and religion were found to be significant predictors for the acceptance of PAS for those in unbearable pain.

Respondents who were older were less likely to strongly agree and the No Preference group was more likely to strongly agree and agree with the acceptance of PAS for those in unbearable pain.

### Acceptance of PAS with Unbearable Pain by Version: Multivariate Analysis

When examining public opinion of the acceptability of PAS for those in unbearable pain by socio-demographic measures for each version, a statistically significant difference was found for the variable of religion in Version B (Appendix C: Table C.2). The criterion for a variable's inclusion in a regression equation was that it was significant at the .05 level in bivariate analysis with the variable of outcome.

Multinomial logistic regression was performed to better understand the relationship between religion and version. For Version B, the -2LL value (104.70) indicated that the predictor variable provided a low level of explanation for the acceptance of PAS for those in unbearable pain (Table 5.16).

The model chi-square is 41.039, which was significant ( $p = .00$ ) indicating that the model did outperform the null hypothesis. The variance in the acceptance of PAS that was accounted for ranges from 10.9% (Cox and Snell) to 11.6% (Nagelkerke) (Munro, 2005).

**Table 5.16: Multivariate Analysis of PAS with Unbearable Pain: Version B<sup>1</sup>**

	Strongly Agree		Agree		Neutral		Disagree	
	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper	OR	95 CI Lower/Upper
<b>Religion<sup>2</sup></b>								
Protestant	.857	.267/2.749	1.060	.355/3.168	.857	.185/3.977	.400	.120/1.331
Catholic	.271	.078/.941	.762	.259/2.238	1.324	.313/5.604	.306	.093/1.006
No Preference	5.769	1.018/32.704	8.053	1.494/43.414	7.500	1.039/54.116	1.000	.151/6.643

2LL = 104.70,  $\chi^2 = 41.039$ ,  $p = .000$

<sup>1</sup> The reference category is strongly disagree.

<sup>2</sup> The reference category is other.

Respondents in the Catholic category were less likely to strongly agree (OR=.271, 95% CI=.078;.941) and respondents in the No Preference group were more likely to strongly agree (OR= 5.769, 95% CI= 1.018; 32.704) with the acceptance of PAS for those in unbearable pain (Table 5.16). Respondents in the No Preference group were also more likely to agree (OR= 8.053, 95% CI=1.494; 43.414) than respondents in other groups.

This section has examined the relationship in each version between the socio-demographic variable of religion and attitudes toward the acceptability of PAS for those in unbearable pain. The No Preference group was more likely to strongly agree and the Catholic group was less likely to strongly agree with the acceptance of PAS for those in unbearable pain for those in Version B.

### **Summary**

This chapter presented the results for the three dependent variables of interest in this study including: public opinion on the legalization of mercy killing; acceptance of PAS; and acceptance of PAS for those who are in unbearable pain. The chapter began by presenting the results of the cross-tabulations and chi-square analysis for PAS and the socio-demographic variables for all respondents and then by Version of the questionnaire. The chapter concluded with the results of the multivariate analysis for PAS, PAS with unbearable pain for all respondents. At the multivariate level, for both of these outcomes the variable of version was not statistically significant.

Chapter Six follows with a discussion of the results, acknowledgement of the limitations of the study, policy implications, the meanings of the findings for the acceptance of PAS and ageism, and recommendations for future research.

## **CHAPTER SIX: DISCUSSION & CONCLUSION**

### **Chapter Introduction**

This chapter will begin with a discussion of the results of the research. This discussion will make reference to the conceptual framework guiding the study and will incorporate existing literature. The chapter concludes by recognizing the limitations and implications of the study, as well as making recommendations for future research.

### **The Acceptance of PAS**

This main goal of this study was to examine ageist attitudes and their possible impact on opinions about PAS. Researchers have in the past disagreed about whether ageist attitudes actually have an impact on older Canadians and the current debate concerning euthanasia and physician-assisted suicide provided an opportunity for investigating the impact of ageist opinions by including the Palmore's Fact of Aging Quiz and PAS questions varied by age (Chappell et al., 2003; Novak and Campbell, 2001).

Research has indicated that the majority of Canadians support physician-assisted suicide (Frileux et al., 2003; Wilson et al., 2000). Concern about the abuse of PAS for those who are vulnerable has been expressed in the argument about the slippery slope. Persons who are older are one such group and some fear that they would be at risk should PAS be legalized. Although there has been a great deal of discussion about the slippery slope there has been little research done that would provide a better understanding of its practical implications.

This study used a random sample of 750 Winnipeggers to examine opinions about PAS in an effort to better understand ageism and whether it plays a role in the acceptability of PAS. The two concepts of central significance in this study, ageism and PAS, were measured by employing a split-half design in which two versions of the survey were administered to determine whether acceptability of PAS for those having an incurable illness differed on the basis of age, i.e., whether the patient was 80 or 40 years old. Further employing the split-half design, respondents were asked a second time whether the acceptability of PAS for those suffering unbearable pain from an incurable illness differed on the basis of age, i.e., whether the patient was 80 or 40 years old. All other questions were the same in both versions including a question about the legalization of mercy killing in Canada.

For all three questions, first for the legalization of mercy killing, second for the acceptance of PAS, and third for the acceptance of PAS for those in unbearable pain, the variables of age and religion were statistically significant. That is, younger respondents and those in the No Preference religious group were more likely to be accepting of PAS. Also for the question about the acceptability of PAS, the variable of gender was also significant with males (68.3%) more likely than females (56.3%) to agree or strongly agree with the acceptance of PAS.

### **Research Question #1**

The first research question addressed in both versions asked the respondent if Canada should legalize mercy killing. The majority of respondents who answered the question (60.6%) agreed or strongly agreed that Canada should have a similar law to the Netherlands

that makes it legal for a doctor to end a person's life in certain situations by using an overdose of drugs. Although a majority, it is less than the 75 percent of Canadians that Gallup reportedly found in 1991 (Bozinoff and MacIntosh, 1991) and 1996 (Elash, 1997). Perhaps the inclusion of death being imminent in the question explains the increase in acceptability seen in the Gallup statistics. Two studies found more similar responses to this study. One study in 1995 from the province of Alberta found that one half to two thirds of the general population and terminally ill patients agreed with the legalization of euthanasia and assisted suicide (Suarez-Almzor, Belzille, and Bruera, 1997). Another Gallup in 1992 from the United States, found that 65% of respondents believed that a doctor should be allowed to end a person's life if he or she requested it (Clarke, 1997).

The findings of the research indicated a relationship between select socio-demographic variables and attitudes toward mercy killing. The socio-demographic variables of religion and age of respondent were found to be statistically significant but weakly related. Respondents in the No Preference category were more likely to agree or strongly agree and respondents who are older were more likely to disagree or strongly disagree with the legalization of mercy killing. Gallup reported in 1991 similar findings with regard to age from Canadians, with those 65 and older less likely to accept legalized mercy killing (Bozinoff and MacIntosh, 1991). In this study, with respect to ageism the Palmore's Quiz Scores indicated that persons in the pro-aged group were more likely to agree or strongly agree and that the relationship between the variables approached statistical significance. According to Palmore (1977) this quiz measures ageism and was included in this study for this purpose.

## Research Question #2

The second research question utilized the split-half design and asked if PAS was acceptable. The majority of the respondents who answered the question about the acceptability of PAS agreed or strongly agreed (61.5%) that if a person is suffering because of an incurable illness and wishes to die that PAS is acceptable. This is similar to the findings of research question #1 (60.6%). At the bivariate level survey version was not statistically significantly related to the acceptability of PAS using the criteria of this study. Although there was a trend for greater acceptance for older targets the variable of version did not reach significance. The sociodemographic variables of gender, age, and religion were statistically significant for the acceptance of PAS. Males, younger respondents, and respondents in the No Preference religious group were more likely to agree with the acceptance of PAS. This is supported by other research that found that younger, nonreligious males were more likely to support lenient attitudes toward suicide and assisted suicide (Seidlitz, L. Duberstein, P. R., Cox, C. and Conwell, Y, 1995).

Multinomial logistic regression was performed to better understand the relationship between the variables. At the multivariate level, those who were younger, male, and in the No Preference category for religion were more likely to strongly agree with the acceptance of PAS. The odds of respondents strongly agreeing with the acceptance of PAS were less for older rather than younger respondents. Males were more likely to agree with the acceptance of PAS than females. Respondents in the No Preference group were more likely to agree and strongly agree about the acceptance of PAS.

When examining public opinion of the acceptability of PAS by socio-demographic measures for each version, statistically significant differences varied according to the

version. The variables of age and religion were significant for version A with younger persons and those in the No Preference group more likely to agree and the variable of religion was significant for version B for those in No Preference group more likely to agree. It is important to note that there was a trend for PAS to be more acceptable for the target person aged 80 (65.3%) rather than the target person aged 40 (58%).

Multinomial Logistic Regression indicated that age and religion was statistically significant for the acceptance of PAS in Version A. Respondents who were older were less likely to strongly agree and agree with the acceptance of PAS for the 80 year old target. Respondents in this version who were in the No Preference category for religion were also more likely to strongly agree and agree with the acceptance of PAS.

For Version B the likelihood ratio indicated that the variable of religion was significant to the model. Respondents in the No Preference category were more likely to strongly agree and to agree about the acceptance of PAS.

### **Research Question #3**

The third research question also utilized the split-half design and asked if PAS was acceptable for those in unbearable pain. The majority of the respondents agreed or strongly agreed (67.8%) with the acceptance of PAS, which is slightly higher for this version of the question than the original version that omitted unbearable pain (61.5%). Research has found that intractable physical suffering make life ending interventions more acceptable (Guedj, Gibert, Maudet, Munoz Sastre, Mullet, and Sorum, 2005). There was no difference for the version of the questionnaire, that is, it did not matter whether the target person was 80 or 40 years old. However, the variables of age and

religion were significant with respondents in the No Preference group expressing greater acceptance and respondents who are older expressing greater disagreement with the acceptance of PAS.

For those in unbearable pain, multinomial logistic regression including the variable of age and religion Older respondents were less likely to strongly agree and agree with the acceptance of PAS for those in unbearable pain. The No Preference group in religious preferences was most likely to strongly agree and agree than other categories for religion.

When examining public opinion of the acceptability of PAS for those in unbearable pain by socio-demographic measures for each version, a statistically significant difference was found for religion in Version B (40 year old). Multinomial logistic regression indicated that the No Preference group was more likely to strongly agree and the Catholic group was less likely to strongly agree with the acceptance of PAS in Version B.

### **Ageism and PAS**

The concept of ageism was used to frame the design and analysis for this study. This study used a split-half design to attempt to capture the notion of ageism and it also used Palmore's Facts of Aging Quiz to explore the impact of ageism on the findings. The relationship between Palmore Quiz Scores and the outcomes of this study do not offer any strong findings that lead to the interpretation that ageism influences agreement or disagreement with PAS. As found in other Canadian research (Martin Matthews, Tindale, and Norris, 1984; Norris, Tindale, and Martin Matthews, 1987) this research was unable to substantiate Palmore's Quiz Scores as providing a measure of ageism.

The combining of measures of PAS and ageism provided the basis of this study. The subject matter of PAS and ageism are both large topics and would benefit from further exploration allowing for alternative operationalization of the concepts. This would in turn provide more information and a greater understanding of the relationship between ageism and PAS.

### **Recommendations for Future Research**

This study has made a contribution to the research literature on ageism and PAS. It is a preliminary study because it was designed to examine the possibility of a relationship between ageism and acceptance due to the lack of previous research in this area. The results have offered no clear answer to the question of whether acceptance of PAS is influenced by ageist attitudes. As a trend, greater acceptance for older adults was found, which may provide support for those who are concerned about the slippery slope. More research needs to be done in this area to examine why there is greater acceptance for older adults and the circumstances under which PAS is more acceptable for older adults. Qualitative research may also help to expand the understanding of ageist opinions and their impact on acceptability of PAS.

This research should serve as a springboard for further investigation into the area and because an age bias trend was discovered there is need for further research. Further research could also focus on other vulnerable populations and PAS.

### **Limitations of this Research**

This research is limited to opinions of those people living in Winnipeg, Manitoba and is unable to expand on the reasons for the relationship between age and acceptance. As previously mentioned, this study is limited to discovering the existence of relationships but not able to explain why they exist.

The data set was limited to information that could be gathered in a telephone survey which inhibits a greater understanding of the issue. Further, the number of questions that the researcher was able to include in the survey was limited by space, money, and time constraints.

### **Implications for Older Adults**

One implication of this research is that the slippery slope argument may have practical implications that need to be considered before changes to PAS legislation are considered. Many questions remain unanswered in this research. For example, would PAS be less acceptable if people knew that they would be comfortable at the end of life? Older adults wish to have good endings to their lives, which means access to all the health care resources like palliative care and hospice at the end of life (Ross, 1998). The importance of good end of life care cannot be over emphasized. If people know that they will not be allowed to suffer endlessly or alone then PAS may not be as acceptable.

Caution needs to be used when approaching this controversial issue. There is reason to believe that opinions about age may influence the acceptability of PAS. The slippery slope argument may have practical implications that put the older person and other vulnerable persons at risk should policy or legislation be changed to make PAS a reality

in Canada. Further, good palliative care needs to be available to the older dying person prior to any consideration of changes to PAS legislation. With the population aging and people living longer, death and dying become more of a public issue. The issue of PAS remains in the forefront and very controversial. Vulnerable persons need to be protected and assured that they will not be at risk from changes to PAS legislation.

### **Conclusion**

This study has examined ageism and acceptance of PAS. The chapter reviewed the major findings of the three research questions on the legalization of mercy killing, the acceptability of PAS, and the acceptability of PAS for those in unbearable pain. The study found that there is a trend toward greater acceptance for older targets suggesting that ageism may play a role in the acceptance of PAS. This lends support to the arguments of proponents of the slippery slope who are concerned about vulnerable and devalued persons being at risk should changes take place to PAS legislation or policy.

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## Appendix A: Research Questions

Sex of respondent

- 1 .... Male
- 2 .... Female

Age of Respondent

- Actual age in years .... \_\_
- 99 .... NR

**The next set of questions deals with making decisions about life and death.**

**Version A:**

28. Suppose that an 80 year old person is suffering because of an incurable illness and wishes to die. I am going to read a statement and I'd like you to please tell me whether you: (READ) Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree.

A competent doctor should be able to end that person's life if that person makes a formal request in writing.

- 5 .... Strongly Agree (Ask Q#29)
- 4 .... Agree (Ask Q#29)
- 3 .... Neither Agree nor Disagree (Go to Q#33)
- 2 .... Disagree (Go to Q#31)
- 1 .... Strongly Disagree (Go to Q#31)
- 8 .... DK (Go to Q#33)
- 9 .... NR (Go to Q#33).

**Version B:**

28. Suppose that an 40 year old person is suffering because of an incurable illness and wishes to die. I am going to read a statement and I'd like you to please tell me whether you: (READ) Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree.

A competent doctor should be able to end that person's life if that person makes a formal request in writing.

- 5 .... Strongly Agree (Ask Q#29)
- 4 .... Agree (Ask Q#29)
- 3 .... Neither Agree nor Disagree (Go to Q#33)
- 2 .... Disagree (Go to Q#31)
- 1 .... Strongly Disagree (Go to Q#31)
- 8 .... DK (Go to Q#33)
- 9 .... NR (Go to Q#33).

*Questions 33 deals with the acceptability of PAS based on age and pain.*

**Version A:**

33. Suppose that an 80 year old person is suffering from unbearable pain because of an incurable illness and wishes to die. I am going to read a statement and I'd like you to please tell me whether you: (READ) Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree.

A Competent doctor should be able to end that person's life if that person makes a formal request in writing.

- 5 .... Strongly Agree (Ask Q#34)
- 4 .... Agree (Ask Q#34)
- 3 .... Neither Agree nor Disagree (Go to Q#38)
- 2 .... Disagree (Go to Q#36)
- 1 .... Strongly Disagree (Go to Q#36)
- 8 .... DK (Go to Q#38)
- 9 .... NR (Go to Q#38)

**Version B:**

33. Suppose that an 40 year old person is suffering from unbearable pain because of an incurable illness and wishes to die. I am going to read a statement and I'd like you to please tell me whether you: (READ) Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree.

A Competent doctor should be able to end that person's life if that person makes a formal request in writing.

- 5 .... Strongly Agree (Ask Q#34)
- 4 .... Agree (Ask Q#34)
- 3 .... Neither Agree nor Disagree (Go to Q#38)
- 2 .... Disagree (Go to Q#36)
- 1 .... Strongly Disagree (Go to Q#36)
- 8 .... DK (Go to Q#38)
- 9 .... NR (Go to Q#38)

*Question 38 solicits opinions on PAS*

38. The Dutch government is introducing a law that would legalize mercy-killing. This would make it legal for a doctor to end a person's life in certain situations by using an overdose of drugs. For example, if a person was suffering from unbearable pain that could not be treated because of a terminal illness. Do you: (READ) (Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree) that we should have a similar law in Canada?

- 5 .... Strongly Agree (Ask Q#39)
- 4 .... Agree (Ask Q#39)
- 3 .... Neither Agree nor Disagree (Go to Q#41)
- 2 .... Disagree (Go to Q#40)
- 1 .... Strongly Disagree (Go to Q#40)
- 8 .... DK (Go to Q#41)
- 9 .... NR (Go to Q#41)

41. In general, how would you describe your health? Would you say that it is: (READ)

- 5 .... Excellent
- 4 .... Very Good
- 3 .... Good
- 2 .... Fair
- 1 .... Poor
- 8 .... DK
- 9 .... NR

*Question 47 measures ageism using a version of Palmore's Facts on Aging Scale.*

**The next question deals with Canadians age 65 and over.**

47. I am going to read a list of statements that express a variety of different opinions about this age group. For each one, please tell me whether you think the statement is True or False.

- a) The majority of people past age 65 are senile (ie. Defective memory, disoriented or demented).
  - 1.... True
  - 2.... False
  - 8 ....DK
  - 9.... NR

- b) All five senses tend to decline with age.  
1.... True  
2.... False  
8.... DK  
9 ....NR
- c) Most older people have no interest in, or capacity for, sexual relations.  
1.... True  
2.... False  
8.... DK  
9 ....NR
- d) Lung capacity tends to decline in old age.  
1.... True  
2.... False  
8.... DK  
9....NR
- e) The majority of old people feel miserable most of the time.  
1.... True  
2.... False  
8.... DK  
9....NR
- f) Physical strength tends to decline in old age.  
1.... True  
2.... False  
8.... DK  
9....NR
- g) At least one-tenth of the aged are living in long-stay institutions (ie. Nursing homes, mental hospitals, homes for the aged etc).  
1.... True  
2.... False  
8.... DK  
9....NR
- h) Aged drivers have fewer accidents per person than drivers under age 65.  
1.... True  
2.... False  
8.... DK  
9....NR
- i) Most older workers cannot work as effectively as younger workers.  
1.... True  
2.... False  
8.... DK  
9....NR
- j) About 80% of the aged are healthy enough to carry out their normal activities.  
1.... True  
2.... False  
8.... DK  
9....NR

- k) Most old people are set in their ways and unable to change.  
1....True  
2....False  
8....DK  
9....NR
- l) Old people usually take longer to learn something new.  
1....True  
2....False  
8....DK  
9....NR
- m) It is almost impossible for most old people to learn new things.  
1....True  
2....False  
8....DK  
9....NR
- n) The reaction time of most old people tends to be slower than the reaction time of younger people.  
1....True  
2....False  
8....DK  
9....NR
- o) In general, most older people are pretty much alike.  
1....True  
2....False  
8....DK  
9....NR
- p) The majority of old people are seldom bored.  
1....True  
2....False  
8....DK  
9....NR
- q) The majority of old people are socially isolated and lonely.  
1....True  
2....False  
8....DK  
9....NR
- r) Older workers have fewer accidents than younger workers.  
1....True  
2....False  
8....DK  
9....NR
- s) Over 20% of the Canadian population are now age 65 or over.  
1....True  
2....False  
8....DK  
9....NR

- t) Most medical practitioners tend to give lower priority to the aged.  
1....True  
2....False  
8....DK  
9....NR
- u) The majority of older people have incomes below the low-income cut-off (as defined by the Federal government).  
1....True  
2....False  
8....DK  
9....NR
- v) The majority of old people are working or would like to have some kind of work to do (including housework and volunteer work).  
1....True  
2....False  
8....DK  
9....NR
- w) Older people tend to become more religious as they age.  
1....True  
2....False  
8....DK  
9....NR
- x) The majority of old people are seldom irritated or angry.  
1....True  
2....False  
8....DK  
9....NR
- y) The health of older people, compared to younger people, in the year 2020 will probably be about the same as now.  
1....True  
2....False  
8....DK  
9....NR
- z) The socio-economic status of older people, compared to younger people, in the year 2020 will probably be about the same as now.  
1....True  
2....False  
8....DK  
9....NR

**Next, I would like to ask you some questions about education and religion.**

67. What is your highest level of education (this includes complete and incomplete)?

Respondent

09....No Schooling

**Elementary School**

02....Incomplete

03....Complete

**Junior High School**

04....Incomplete

05....Complete

**High School**

06....Incomplete

07....Complete (GED)

**Non-University (Voc/Tech, Nursing Schools)**

08....Incomplete

09....Complete

**University**

10....Incomplete

11....Diploma/Certificate (e.g. Hygenists)

12....Bachelor's Degree

13....Professional Degree (Vets, Drs., Dentists, Lawyers)

14....Master's Degree

15....Doctorate

97....No Spouse

98....DK

99....NR

68a. What is your religious preference, if any? (CIRCLE CATEGORY BELOW)

01....Anglican

02....Baptist

03....Greek Orthodox

04....Jewish

05....Lutheran

06....Mennonite

07....Mormon

08....Pentecostal

09....Presbyterian

10....Roman Catholic

11....Ukrainian Catholic

12....United Church

13....Protestant Unspecified

14....Christian Unspecified

15....Moslem

- 16... Other Eastern Religions
- 17... Atheist
- 18... Agnostic
- 19... No Preference/Affiliation (Go to Q#69a)
- 20... Other (specify: \_\_\_\_\_)
- 98... DK
- 99... NR

68b. Would you call yourself strong or not very strong (READ STATED RELIGIOUS PREFERENCE FROM ABOVE)?

- 1... Strong
- 2... Not Very Strong
- 3... Somewhat Strong (Volunteered)
- 7... NA
- 8... DK
- 9... NR

**If Respondent is Agnostic or Atheist, go to Q#69a)**

68c. How often do you attend services at a church (or a synagogue or temple or other place of worship) Would you say: (READ)?

- 1... Never or Hardly Ever
- 2... One-to-Three Times a Year
- 3... Four-to-Eleven Times a Year
- 4... One-To-Three Times a Month
- 5... Once a Week
- 6... More Than Once a Week
- 7... NA
- 8... DK
- 9... NR

## Appendix B: Interviewer Instructions

Interviewers were given the following instructions:

- If the person answering the phone is of the gender specified for that phone number, only that person can be interviewed.
- If the person answering the phone is not of the gender specified for the phone number, ask the person to choose an individual of the specified gender in the household for you. No guidelines are to be given for this selection. No substitutions are permitted if the selected person refuses. If the selected person is not at home, or for some reason is not available at that time, every effort must be made to set up an appointment for a telephone interview.
- If a person of the gender specified for that phone number does not live at that residence, the respondent must be the person who answers the phone.

**Appendix C: Acceptance of PAS by Survey Version**  
**Table C:1: Acceptance of PAS by Survey Version**

	Acceptance of PAS				
	Strongly Disagree %	Disagree %	Neither Agree Nor Disagree %	Agree %	Strongly Agree %
<b>GENDER</b>					
<b>Version A (n=354)</b>					
Male (n=157)	10.8	10.8	6.4	41.4	30.6
Female (n=197)	10.2	16.2	13.7	35.0	24.9
$\chi^2 = 8.363, p = .079, \text{Cramer's } V = .154$					
<b>Version B (n=364)</b>					
Male (153)	9.8	13.1	12.4	45.8	19.0
Female (211)	17.1	17.1	12.8	35.1	18.0
$\chi^2 = 6.862, p = .143, \text{Cramer's } V = .137$					
<b>AGE</b>					
<b>Version A (n=344)</b>					
18-24 (n=46)	2.2	19.6	13.0	32.6	32.6
25-34 (n=69)	2.9	8.7	14.5	43.5	30.4
35-44 (n=76)	10.5	17.1	7.9	38.2	26.3
45-54 (n=70)	11.4	7.1	8.6	38.6	34.3
55-64 (n=33)	15.2	21.2	3.0	33.3	27.3
65+ (n=50)	22.0	16.0	12.0	38.0	12.0
$\chi^2 = 32.262, p = .041, \text{Cramer's } V = .153$					
<b>Version B (n=357)</b>					
18-24 (n=55)	3.6	14.5	12.7	49.1	20.0
25-34 (n=67)	10.4	17.9	11.9	46.3	13.4
35-44 (n=82)	11.0	15.9	13.4	40.2	19.5
45-54 (n=70)	22.9	7.1	12.9	37.1	20.0
55-64 (n=30)	10.0	23.3	16.7	30.0	20.0
65+ (n=53)	22.6	18.9	9.4	30.2	18.9
$\chi^2 = 23.765, p = .253, \text{Cramer's } V = .129$					
<b>INCOME</b>					
<b>Version A (n=354)</b>					
<\$20,000 (n=74)	18.9	13.5	12.2	29.7	25.7
\$20,000-\$39,999(n=88)	12.5	15.9	8.0	40.9	22.7
\$40,000-\$59,999(n=49)	4.1	14.3	4.1	46.9	30.6
>\$60,000 (n=143)	7.0	12.6	13.3	30.1	37.1
$\chi^2 = 17.087, p = .146, \text{Cramer's } V = .127$					
<b>Version B (n=364)</b>					
<\$20,000 (n=99)	16.2	18.2	10.1	36.4	19.2
\$20,000-\$39,999(n=84)	11.9	20.2	16.7	33.3	17.9
\$40,000-\$59,999(n=39)	20.5	10.3	7.7	46.2	15.4
>\$60,000 (n=142)	12.0	12.0	13.4	43.7	19.0
$\chi^2 = 10.502, p = .572, \text{Cramer's } V = .098$					

Table C.1: Acceptance of PAS by Survey Version (continued)

	Acceptance of PAS				
	Strongly Disagree %	Disagree %	Neither Agree Nor Disagree %	Agree %	Strongly Agree %
<b>RELIGION</b>					
<b>Version A (n=349)</b>					
Protestant (n=104)	14.4	16.3	10.6	28.8	29.8
Catholic (n=98)	10.2	14.3	11.2	42.9	21.4
No Preference(n=94)	4.3	5.3	9.6	46.8	34.0
Other (n=53)	15.1	18.9	11.3	30.2	24.5
$\chi^2 = 21.572, p = .043, \text{Cramer's } V = .144$					
<b>Version B (n=355)</b>					
Protestant (n=107)	14.0	13.1	12.1	39.3	21.5
Catholic (n=95)	22.1	20.0	13.7	34.7	9.5
No Preference (n=94)	2.1	7.4	13.8	51.1	25.5
Other (n=59)	15.3	25.4	10.2	30.5	18.6
$\chi^2 = 36.410, P = .000, \text{Cramer's } V = .185$					
<b>EDUCATION</b>					
<b>Version A (n= 354)</b>					
Junior High Or Less (n=18)	22.2	11.1	11.1	27.8	27.8
High School, Other Non-University (n=209)	9.1	12.5	7.7	43.3	27.4
Some University(n=129)	10.9	16.4	14.8	30.5	27.3
$\chi^2 = 11.560, p = .172, \text{Cramer's } V = .128$					
<b>Version B (n= 359)</b>					
Junior High Or Less (n=15)	6.7	20.0	6.7	40.0	26.7
Other Non-University (n=212)	13.7	15.6	9.9	41.0	19.8
Some University(n=132)	13.6	14.4	17.4	38.6	15.9
$\chi^2 = 6.240, p = .620, \text{Cramer's } V = .093$					
<b>RATINGS OF HEALTH</b>					
<b>Version A (n=354)</b>					
Fair/Poor (n=40)	12.5	10.0	7.5	40.0	30.0
Good (n=84)	11.9	16.7	13.1	33.3	25.0
Very Good (n=140)	8.6	14.3	6.4	42.1	28.6
Excellent (n=88)	10.2	12.5	15.9	34.1	27.6
$\chi^2 = 9.239, p = .682, \text{Cramer's } V = .094$					

**Table C.1: Acceptance of PAS by Survey Version (continued)**

	Acceptance of PAS				
	Strongly Disagree %	Disagree %	Neither Agree Nor Disagree %	Agree %	Strongly Agree %
<b>Version B (n=360)</b>					
Fair/Poor (n=41)	19.5	17.1	9.8	39.0	14.6
Good (n=92)	17.4	15.2	8.7	40.2	18.5
Very Good (n=152)	9.9	17.8	15.1	37.5	19.7
Excellent (n=75)	16.0	8.0	14.7	44.0	17.3
$\chi^2 = 10.424, p = .579, \text{Cramer's } V = .098$					
<b>PALMORE QUIZ SCORES</b>					
<b>Version A (n=354)</b>					
Pro-aged (n=167)	6.6	15.0	10.2	41.3	26.9
Anti-aged (n=187)	13.9	12.8	10.7	34.8	27.8
$\chi^2 = 5.858, p = .210, \text{Cramer's } V = .129$					
<b>Version B (n=364)</b>					
Pro-aged (n=179)	11.2	18.4	11.7	40.2	18.4
Anti-aged (n=185)	16.8	12.4	13.5	38.9	18.4
$\chi^2 = 4.423, p = .352, \text{Cramer's } V = .110$					

Table C.2: Acceptance of PAS by Survey Version with Unbearable Pain

	Acceptance of PAS				
	Strongly Disagree %	Disagree %	Neither Agree Nor Disagree %	Agree %	Strongly Agree %
<b>GENDER</b>					
<b>Version A (n=356)</b>					
Male (n=156)	9.6	12.8	4.5	44.9	28.2
Female (n=200)	10.0	12.5	8.5	43.0	26.0
$\chi^2 = 2.342, p = .673, \text{Cramer's } V = .081$					
<b>Version B (n=364)</b>					
Male (153)	8.5	13.1	7.2	49.7	21.6
Female (211)	13.3	13.7	12.8	40.3	19.9
$\chi^2 = 6.381, p = .172, \text{Cramer's } V = .132$					
<b>AGE</b>					
<b>Version A (n=347)</b>					
18-24 (n=46)	0	19.6	13.0	37.0	30.4
25-34 (n=69)	4.4	10.3	4.4	47.1	33.8
35-44 (n=76)	13.2	10.5	6.6	43.4	26.3
45-54 (n=70)	10.0	5.7	7.1	45.7	31.4
55-64 (n=33)	11.8	17.6	5.9	41.2	23.5
65+ (n=50)	17.0	20.8	5.7	43.4	13.2
$\chi^2 = 28.604, p = .096, \text{Cramer's } V = .144$					
<b>Version B (n=358)</b>					
18-24 (n=55)	3.6	12.5	7.1	51.8	25.0
25-34 (n=67)	9.0	13.4	9.0	52.2	16.4
35-44 (n=82)	7.4	11.1	12.3	46.9	22.2
45-54 (n=70)	19.7	8.5	11.3	39.4	21.1
55-64 (n=30)	13.3	13.3	16.7	36.7	20.0
65+ (n=53)	13.2	24.5	9.4	34.0	18.9
$\chi^2 = 23.218, p = .278, \text{Cramer's } V = .127$					
<b>INCOME</b>					
<b>Version A (n=356)</b>					
<\$20,000 (n=76)	17.1	14.5	3.9	36.8	27.6
\$20,000-\$39,999 (n=89)	12.4	13.5	7.9	46.1	20.2
\$40,000-\$59,999 (n=48)	6.3	14.6	0	47.9	31.3
>\$60,000 (n=143)	5.6	10.5	9.8	44.8	29.4
$\chi^2 = 18.384, p = .105, \text{Cramer's } V = .127$					
<b>Version B (n=364)</b>					
<\$20,000 (n=96)	9.4	19.8	8.3	42.7	19.8
\$20,000-\$39,999 (n=86)	10.5	11.6	12.8	43.0	22.1
\$40,000-\$59,999 (n=37)	18.9	10.8	10.8	45.9	13.5
>\$60,000 (n=145)	11.0	11.0	10.3	45.5	22.1
$\chi^2 = 8.389, p = .754, \text{Cramer's } V = .088$					

**Table C.2: Acceptance of PAS by Survey Version with Unbearable Pain (continued)**

		Acceptance of PAS				
		Strongly Disagree %	Disagree %	Neither Agree Nor Disagree %	Agree %	Strongly Agree %
<b>RELIGION</b>						
<b>Version A (n=352)</b>						
Protestant (n=107)	14.4	16.3	10.6	28.8	29.8	
Catholic (n=98)	10.2	14.3	11.2	42.9	21.4	
No Preference(n=94)	4.3	5.3	9.6	46.8	34.0	
Other (n=53)	15.1	18.9	11.3	30.2	24.5	
$\chi^2 = 17.988, p = .116, \text{Cramer's } V = .131$						
<b>Version B (n=355)</b>						
Protestant (n=109)	14.0	13.1	12.1	39.3	21.5	
Catholic (n=96)	22.1	20.0	13.7	34.7	9.5	
No Preference (n=93)	2.1	7.4	13.8	51.1	25.5	
Other (n=57)	15.3	25.4	10.2	30.5	18.6	
$\chi^2 = 37.925, p = .000, \text{Cramer's } V = .189$						
<b>EDUCATION</b>						
<b>Version A (n= 356)</b>						
Junior High Or Less (n=18)	22.2	11.1	5.6	33.3	27.8	
High School, Other Non- University (n=209)	7.7	12.0	4.8	49.3	26.3	
Some University(n=129)	11.6	14.0	10.1	36.4	27.9	
$\chi^2 = 11.441, p = .178, \text{Cramer's } V = .127$						
<b>Version B (n= 359)</b>						
Junior High Or Less (n=15)	6.7	13.3	13.3	13.3	33.3	
High School, Other Non- University (n=211)	10.4	14.7	9.5	9.5	23.2	
Some University(n=133)	12.0	10.5	11.3	11.3	15.8	
$\chi^2 = 6.926, p = .545, \text{Cramer's } V = .098$						
<b>RATINGS OF HEALTH</b>						
<b>Version A (n=352)</b>						
Fair/Poor (n=40)	7.5	10.0	2.5	52.5	27.5	
Good (n=84)	11.5	14.9	9.2	41.4	23.0	
Very Good (n=140)	8.5	13.5	5.7	43.3	29.1	
Excellent (n=88)	10.5	10.5	8.1	43.0	27.9	
$\chi^2 = 5.644, p = .933, \text{Cramer's } V = .073$						

**Table C.2: Acceptance of PAS by Survey Version with Unbearable Pain (continued)**

	Acceptance of PAS				
	Strongly Disagree %	Disagree %	Neither Agree Nor Disagree %	Agree %	Strongly Agree %
<b>Version B (n=360)</b>					
Fair/Poor (n=41)	7.5	20.0	5.0	47.5	20.0
Good (n=92)	14.3	15.4	12.1	36.3	22.0
Very Good (n=152)	8.6	13.9	9.9	47.7	19.9
Excellent (n=75)	14.1	7.7	12.8	44.9	20.5
$\chi^2 = 9.956, p = .620, \text{Cramer's } V = .096$					
<b>PALMORE QUIZ SCORES</b>					
<b>Version A (n=356)</b>					
Pro-aged (n=170)	7.1	10.6	7.1	49.4	2C
Anti-aged (n=186)	12.4	14.5	6.5	38.7	28.0
$\chi^2 = 6.140, p = .189, \text{Cramer's } V = .131$					
<b>Version B (n=364)</b>					
Pro-aged (n=179)	10.1	16.8	10.1	40.8	22.3
Anti-aged (n=185)	12.4	10.3	10.8	47.6	18.9
$\chi^2 = 4.818, p = .307, \text{Cramer's } V = .115$					