

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

By

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Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
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Public Opinions of Physician-Assisted Suicide: The Role of Ageism in Acceptance

BY

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**

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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 suicide¹. 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

¹ 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 Kevorkian¹, 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

¹ 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 Schiavo³ 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

³ 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.