ELDERS' OPINIONS ON THE RIGHT TO DIE: FACTORS THAT MAKE A DIFFERENCE

_____

A Thesis

Presented to

The Faculty of the Department of Criminal Justice and Criminology

Sam Houston State University

_____

In Partial Fulfillment

of the Requirements for the Degree of

Master of Arts

_____

by

Adrianna Medina

May, 2017

ELDERS' OPINIONS ON THE RIGHT TO DIE: FACTORS THAT MAKE A DIFFERENCE

by

Adrianna Medina

_____

APPROVED:

Victoria Titterington, PhD
Thesis Director

Yan Zhang, PhD
Committee Member

John Payne, PhD
Committee Member

Phillip Lyons, PhD
Dean, College of Criminal Justice

ABSTRACT

Medina, Adrianna, *Elders' opinions on the right to die: Factors that make a difference*. Master of Arts (Criminal Justice and Criminology), May, 2017, Sam Houston State University, Huntsville, Texas.

Given that the elder segment of the United States' population will soon account for 20% of our overall population, the opinions and welfare of our elders has become increasingly important. This has led to the resurgence of interest in Right to Die laws. With six U.S. states and the District of Columbia having passed right to die laws, which allow physician assisted suicide to be used in specific circumstances, the need for elders' opinions on the matter arose. This exploratory study has looked into what sociodemographic factors, specifically the increase of age, affect elders' opinions on physician assisted suicide. Using a Pew Research Data set with descriptive and chi square statistics to analyze bivariate and multivariate interactions within the data set. The data set consisted of a nationwide sample of 690 people age 18 to 99 years old. Age, race, religion and marital status all had significant effects on a person's opinion of PAS. When controlling for religion age did have a significant interaction with PAS response in the religions of Catholicism and Judaism.

The findings from these future studies would greatly contribute to the areas of public policy/legislation, end of life decisions and the right to die movement by informing advocacy groups, state senates, state houses, healthcare providers and our government where regions are standing on PAS and most importantly which segments of the population will change their opinions over time. As the opinions of youth have been proven to be different in certain sociodemographic variables it is important for law

makers to know the trends of how these age groups will change, and what segment of the population they possess, so that it can be accounted for when making policy.

KEY WORDS: PAS, Physician Assisted Suicide, Right to Die, Death with Dignity, Elder, Age, Religion, Marital Status, Race, Gender, Opinion, End of Life

TABLE OF CONTENTS

Page

LIST OF TABLES

Table **Page**

CHAPTER I

Introduction

Older persons in the U.S. will soon be 20% of the overall population. A major reason for this phenomenon is that advances in healthcare have resulted in longer life expectancies, including a prolonged period for many older persons wherein health is not optimal. This, along with the fact that older adults are the most likely segment of the population to which physician-assisted suicide (PAS) may apply, it is surprising that there has been little research looking into the opinions of elders on PAS in the United States. While there are numerous polls on the general morality of PAS, there has not been a study which looks into the interaction of an elder's race, age, gender, religion, marital status, and political affiliation with their belief for or against PAS. This exploratory thesis will look into what factors affect elder's opinions on right-to-die related issues, specifically physician assisted suicide (PAS), in an effort to see how this end of life care is received.

Here in the United States there are currently six states and most recently our nation's capital with legal PAS. There continues to be wide debate over the morality of PAS and whether it is ethical for doctors to legally help a patient commit suicide. This debate has been ongoing in the U.S. since 1997 when the state of Florida introduced a right to die bill, which never passed (Humphry, 2008). In a recent 2013 research poll, Americans were found to be against PAS laws by 49% of surveyed participants (Pew Research Center, 2013). With the numbers, so close to being split, one has to wonder where elders stand on the subject. In turn, it is important for lawmakers and doctors to know how the majority of elders view such decisions and what fears they may have about

this issue as it is an end of life care treatment. This is important as legislation is in a position to safeguard our elders' fear(s) before new laws are passed. Should elders dislike or fear that PAS will be wrongly used against them, then it is a valid area of interest for academics, policymakers and health care professionals to investigate. The country needs to know what, if anything, elders fear about PAS, why they have these fears and how these opinions may inform the national debate moving forward in end of life care options. This is especially important, as this year our nation's capital and the state of Colorado's PAS laws took effect in January.

Physician assisted suicide has a vast array of opinions from the general public, law makers and health care professionals, since it is a very controversial topic. Although there is no set age to be considered elderly, for the purposes of this paper the term will apply to persons 65 years and older. Using a 2005 data set from the Pew Research Center this paper will attempt to explore eight questions:

1. Are elders' opinions on the Physician Assisted Suicide different from those of younger adults?
2. How does race affect peoples' opinions on physician assisted suicide?
3. How does religion affect peoples' opinions on physician assisted suicide?
4. How does marital status affect peoples' opinions on physician assisted suicide?
5. How does gender affect peoples' opinions on physician assisted suicide?
6. How does the combination of age and race affect elders' opinions on physician assisted suicide?
7. How does the combination of age and religion affect elders' opinions on physician assisted suicide?

8. Does age and marital status affect the opinions of elders on physician assisted suicide?

Through testing these eight thesis questions, it is believed that the results will give a better understanding into what factors, particularly age, affect the opinions of elders living in the United States, on the topic of physician-assisted suicide. This is beneficial not only to the academic world but to the medical establishment, law makers, families of elders and elders who are thinking of this option in end-of-life care. Doctors themselves question if they would have the proper ability to make the final call on whether a patient has the clearance to participate in PAS, as it would require the doctor to make an accurate diagnosis of a patient's life expectancy (Lee et al., 1996). Doctors would have to determine if a patient fits into a six month or less life expectancy time frame. This is understandably difficult as the human body is extremely complex and easily misunderstood. There are also the controversies of insurance policies, family members and even doctors pressuring elders toward PAS. As PAS is the most controversial of end of life care options, this will continue to be a topic of public policy debate as our country continues to age.

CHAPTER II

Literature Review

Who is an Elder?

The term elder has often been confusing due to its subjective nature. While there is not a true nationally set age for when a person becomes an elder, many states and even businesses set their own definition of the term. One can walk down the street to a Denny's or an IHOP to find anyone over the age of 55 would be considered a senior and receive the senior citizen discount (denny's.com & ihop.com). Social Security was the first federal agency to set a quasi-national age at 65 years old as the age of retirement and therefore provided an age for the term "elder" (Quadagno, 2014, P. 330). Simply basing the age for elderly from Social Security can be a problem, as the age for full retirement continues to increase. The retirement age for receiving full Social Security benefits has risen from 65 years in 1935 to 67 years in 2015 (ssa.gov). Due to the slowly changing age for receiving full benefits, most people continue to use 65 as the set age for terms such as elderly, older adults or senior citizens. The U.S. Census Bureau also defines an elder as a person 65 years and older in all of their surveys (census.gov).

However, as the starting age for elder can range from 65 to 67, this paper will use the age of 66 as the definition for elder. This puts the selected age in a safe spot to be considered elder as it is in the middle of Social Security's retirement age.

What is Physician Assisted Suicide?

Using Manning's 1998 definition of physician assisted suicide, P.A.S. is defined as the act of a doctor providing the patient with the means, pills or information, to end their own life (Manning, 1998, p. 3). This is a widely-accepted definition of the term and

can be found throughout the academic and medical literature. It is important to note the patient is the one to carry out the final act in committing suicide, not the doctor. In cases where the patient is prescribed a drug, as is generally the case, a fast- acting barbiturate is typically given.

PAS is currently legal in six US states, including Oregon, Washington, Vermont and Montana, California, Colorado and the District of Columbia (ProCon.org). Patients qualify for PAS in that state if they have a terminal illness, that is expected to result in their death within six months or less and is typically 18 years of age or older. Also, the person must make several requests to their health care physician in order for the doctor to consider granting their request (ProCon.org).

Oregon is probably the most known state to have PAS since it is surrounded by controversy due to its Death with Dignity Act. Fortunately, because of the attention Oregon gets, there is a great deal of information on various aspects of their Dying with Dignity laws and practices. In Oregon, a patient is prescribed one of two different drugs, a drug in pill form called Secobarbital or a liquid, Pentobarbital. Once ingested, the patient will generally lose consciousness between one and thirty-seven minutes. After a patient is unconscious the drug overwhelms the patient's body, leading to death, between four minutes and thirty-seven hours later (Hedberk, Hopkins and Kohn 2003).

Euthanasia: Is it the same as PAS?

A common misconception amongst the general population is that physician assisted suicide and euthanasia are two different terms for the same act or definition. In fact, there are three types of euthanasia: passive, voluntary active and involuntary active. Passive euthanasia is the withdrawal of medical treatment in order to let the patient die

and not prolong a definite slow and agonizing death (Manning, 1998, p. 2). Voluntary active euthanasia is done with the consent of the patient, through lethal injection by a doctor, whereas involuntary euthanasia is done without the consent of the patient (Manning, 1998, p. 2). It is important to note that the patient may be unable to make such a decision due to an inadequate or non- functional mental state. They may have a disability impeding their awareness or they could be unconscious, such as in a coma. The United State does not currently have a state where euthanasia is legally practiced. That being said, one could still take a family member off of life support and allow them to die, should they be unlikely to recover. This practice of "pulling the plug", so to speak, is not legally considered euthanasia by US law, though one could argue it is a form of passive euthanasia.

To summarize, in comparing and contrasting PAS and euthanasia, are two significantly different elements. In PAS, it is the patient carrying out the life-ending procedure, and they are provided with the overt means to do so by a medical doctor.

Legalizing PAS in the US

As mentioned, only six states and the District of Columbia currently have legal PAS practices and laws. In 2015 however there were a different six states where PAS could be practiced legally, including Oregon Washington, Vermont, California, Montana and New Mexico. However, New Mexico's Court of Appeals has since overturned the previous ruling and abolished the practice of PAS, making it illegal in the state. Oregon was the first of the six states to legalize PAS in 1994, Washington followed in 2008, Montana in 2009, Vermont in 2013, New Mexico in 2014, California in 2015, Colorado and Washington DC in 2016.

In 1969, Idaho was the first U.S. state to bring right to die bills to the legislative table in the form of voluntary euthanasia, while it obviously did not pass, it opened the gateway for other states to start the legislative process on right to die laws. Florida was the first state to bring a right-to-die bill to legislature which would allow PAS to be practiced in the state in 1967. The bill caused an intense amount of debate but ultimately was rejected (Humphry, 2004). Oregon first introduced its Death with Dignity Act with Washington in 1990, but the act never got past the state's committee level. Therefore in 1993, Oregon created a political action committee to write their new death with dignity act, with hopes that voters would have better inclinations towards this version. The next year in 1994, state voters approved of the new death with dignity act, Ballot Measure 16 (51-49%) and became the first state to have legalized PAS. The implementation of the act was delayed by a U.S. district judge in 1995, ruling the ballot unconstitutional by way of violating the equal protection clause (Humphry, 2004). He was quickly overruled and the state began practicing its famous death with dignity act. It was not until 2006 that Oregon's use of PAS was under the spotlight again. With the U.S. Supreme Court taking the Attorney General's and then President Bush's appeal to repeal the law on grounds of violation of the controlled substances act, as they believed PAS was not a legitimate medical procedure. The U.S. Supreme Court upheld Oregon's death with dignity act, finding that states are responsible for determining what a legitimate medical procedure is and that the drugs prescribed were never intended to be banned drugs (Humphry, 2008). Washington became the first state to have a voter referendum on voluntary euthanasia and PAS, with its Initiative 119 in 1990. However, the following year voters reject the ballot and Washington did not try to pass a PAS bill again until 2006, with senate bill

6843 which again failed. Finally, in 2008 passed its Death with Dignity Act, 51-49%, with the act taking effect the following year. California came onto the death with dignity scene before Oregon with its 1987 resolution, which made the California State Bar the first public body to approve PAS (DeathwithDignity.org). It was not until 1992 that California introduced its death with dignity act under proposition 16 that the state truly entered to PAS debate. The proposition was defeated 54% to 46% by California voters. In 2005, the state tried again with the introduction of the California Compassionate Choices Act, but ultimately passed the End of Life Option Act in 2015. Vermont introduced its death with dignity law in 2005 but did not pass it until 2013, when it became the third state to allow PAS. Montana is the only state to have legalized PAS through a Supreme Court case. *Baxter v. Montana* legalized PAS in selective instances. *Baxter v. Montana* was filed by Robert Baxter, Compassions & Choices and four Montana physicians. Mr. Baxter was dying from Lymphocytic Leukemia and asked the court to establish a ruling allowing terminally ill patients to legally receive PAS from their attending physician (ProCon.org). PAS cannot be openly practiced here and patients must receive a court ruling in order to participate in it. There is no minimum age requirement; in fact, the only requirement other than a favorable court ruling is that the patient must be a legal resident of the state. The five other states' requirements are that the patient must be 18 years of age or older, the patient must have six months or less left to live and must have made a request to a physician verbally twice and once in writing, with each separated by at least 15 days of time (ProCon.org).

Colorado and D.C. have been the most recent additions to the group with both having passed the laws in 2016 and taking effect at the beginning of this year, 2017. In

March of 2017, the state of Hawai'i passed a Death with Dignity bill through its state senate, which when passed by the House and signed by the governor, will legalize the use of PAS within the state. The state has previously failed to get the bill to pass in the senate, but with the right to die movement increasing across the nation and advocacy groups working with jurisdictions and states, the senate passed the bill with 22 in favor and only 3 against it. With the exceptions of Washington, Oregon and Montana all of the current states passed PAS through acts. California and Colorado both passed PAS through separate End of Life Option Acts. Vermont passed PAS through an End of Life Choices Act, while D.C. chose to use the Death with Dignity Act.

As there have been three states, with one withdrawing, and our nation's capitol all passing PAS laws within the past 2-3 years, PAS along with the right to die movement is increasing in national attention and awareness. A great example of this in a broader context is in 2015, where there were 25 states trying to pass PAS bills in legislation, each year more and more states are considering legalizing PAS in their own state. When the right to die movement began in the early 90's very few states went so far as to attempt to pass a bill on PAS (DeathwithDignity.org).

Who is Using Physician Assisted Suicide?

Since 1998 in Oregon, there have been a total of 1,749 people who had received prescriptions in order to end their own life, with 1,127 ingesting the drugs and succeeding in ending their life (Public Health Division & Center for Health Statistics). Oregon shot from 24 people receiving prescriptions, with 16 ingesting the drug in 1998 to 204 people receiving a prescription and 133 people taking the drug in 2016. Due to a patient survey form, which is filled out before death, there is sociodemographic information available on

the patients who ingested the drugs to end their own life. Oregon has collected these forms and issued a yearly report for all nineteen years the state has had PAS. This is extremely beneficial to researchers, state law makers and medical practitioners, specifically, as it all allows for insight into who chooses to use PAS laws. While it can vary from year to year in Oregon, overall males are more likely than females to use PAS. When looking at all of the nineteen years of statistics collected, males accounted for 51% of the users. Surprisingly 96% of the people receiving PAS were white; one would have thought that there would be a mix of racial demographics. The majority of participates were married, 45%, and had at least a bachelor's degree (46%) in higher education. As PAS is typically targeted toward end of life care, it should be no surprise to find the majority of participants, 30%, were in the age ranges of 65-74 years old. This was followed closely by the 75-84-year-old age range at 25%. Cancer, 77%, was cited as the medical reason for requesting and taking the drugs to die, with Secobarbital being prescribed to 59%. 90% were enrolled in hospice care programs with 54% having private insurance, while 44% had Medicare/Medicaid or other government insurance. Not surprisingly 93% of the participants died in the comfort of their own home. When asked why the participant wanted to take the drugs the majority, 91%, cited the loss of autonomy as their reason, followed by the inability to do activates they once loved, 89% (Public Health Division & Center for Health Statistics).

Like Oregon, Washington collects statistics on those who have used PAS, via before death surveys and death certificates. Washington started off in 2009 with 65 people receiving drug prescriptions and 64 of those people taking the drug, leading to their death. The latest published report is from 2015 and shows that 213 people received

prescriptions with 202 deaths from the drugs (Washington State Department of Health). Washington's statistics for each of its reported seven years matches what is found in Oregon's statistics. In 2015, males were 53% of the users with 98% of the year's participants being white. Most were married, 47%, and had at least a bachelor's degree in higher education, 47%. 31% of the deceased were in the 65 to 74 age category and claimed cancer as their medical reason for PAS, 72%. Again, Secobarbital was given to over half of the patients, 52%. 83% of the participants were enrolled in hospice programs with 71% carrying Medicare or Medicaid and only 14% had private insurance. Again, the majority of the participants died in the comfort of their own home, 86%. Loosing ones' autonomy, 89%, and being unable to do what they once loved, 94%, was cited as personal reasons for taking PAS (Washington State Department of Health).

Influential Court Cases

End of life issues such as living wills, finances, medical care, quality of life and the discussion on PAS has in part been brought to the attention of the public through influential court cases. There are five major court cases which helped to spur the right to die movement and led to the creation of PAS laws in several states.

The 1975 New Jersey Supreme Court case of Karen Ann Quinlan became the spearhead of the right-to-die movement through the use of end of life care in the national debate (McFadden,1985). Quinlan, at age 21, had fallen into a sudden comma where doctors decided she was in a persistent vegetative state and would require a respirator to continue living. Her family asked doctors to remove the respirator tube, as she was not going to recover from her coma. When doctors refused, the parents went to the New Jersey Superior Court, where they were denied the right to remove life support for their

daughter (McFadden, 1985). The case was appealed to the New Jersey Supreme Court and on March 31, 1975 the court ruled 7-0 in favor of the family. This ruling set that patients and their family (should they be incapacitated) have a right to terminate life support (Masci, 2013). Once the breathing tube was removed Quinlan died almost ten years later (in 1985) from untreated pneumonia at the age of 31.

In 1990 the right-to-die movement/debate had made its way to the U.S. Supreme Court in *Cruzan v Director, Missouri Department of Health* (Lewin, 1990). Nancy Cruzan was in a car crash in 1983, which left her in a permanent vegetative state, where she required a feeding tube to continue living. Her parents fought the state of Missouri, to remove her feeding tube in order to let her die. The U.S. Supreme Court ruled the family had a constitutional right to refuse treatment in extraordinary circumstances (Masci, 2013). The family had her feeding tube removed and Cruzan died two weeks later.

Perhaps the most well-known case is that of the Terri Schiavo controversy that lasted from 1990 to 2005. Theresa Marie "Terri" Schiavo was a severely brain dead woman who died after her feeding tube was removed in 2005. Terri's husband and legal guardian fought against her parents to remove here feeding tube, stating that his wife would not want to live in a vegetative state for the rest of her life (Masci, 2013). The case was so popular for both right-to-die and pro-life supporters that it was a constant nationwide debate. In the end the court of public opinion and even the U.S. Congress and Florida senator Jeb Bush became involved in the case. During the span of 15 years the family and Michal Schiavo had a total of 14 appeals in the state of Florida. At the insistence of her parents and Florida state senator Jeb Bush congress passed a bill called Terri's Law to prevent the removal of her feeding tube. The law was eventually declared

unconstitutional by the Supreme Court. Ultimately the courts would decide that, as Terri's husband, Michael had the right to decide to remove his wife's feeding tube. Terri would later die on March 31, 2005 after her husband made the final decision to remove her feeding tube. This case sparked outrage amongst Americans who did not believe congress had the right to interfere in end of life care of a patient and should have stayed out of it. In both the 1990 and 2005 study conducted by the Pew Research Center participants responded with an overwhelming majority that congress should not have interfered (Pew Research Center, 2006). It was during the Terri Schiavo case that Oregon became the first state to pass PAS laws in 1994 with the Death with Dignity Act, although it would not come into effect until 1997.

In 1997 *Washington v Glucksberg* brought the issue of assisted suicide to the U.S Supreme Court. In the case, the Court upheld the *Cruzan v Director, Missouri Department of Health* ruling which stated a patient, and their legal guardian, have a constitutional right to refuse medical treatment, but it does not give one the constitutional right to assisted suicide or PAS (Masci, 2013). This case proved to be a setback for PAS supporters but overall did not dampen or slow down the right-to-die movement as five other states went on to pass PAS laws/bills shortly thereafter.

In 2006, *Gonzales v Oregon*, the U.S. Supreme Court put an end to Oregon's battle with the U.S. attorney general which halted its PAS practices from 2001 to 2006. In 1994 when voters passed the Death with Dignity Act, the U.S. Attorney General at the time, Janet Reno, found the state's new act did not violate the Controlled Substances Act (CSA) of 1970. This meant that the procedure PAS was a legitimate medical procedure and therefore the drugs prescribed and filled by physicians and pharmacists were legal.

When a new attorney general, John Ashcroft, was appointed in 2001 he reversed this and effectively put a halt to Oregon's PAS practice which had been up and running for about four years. Ashcroft determined that PAS did not or was not a legitimate medical purpose as defined by the CSA. Therefore, doctors and pharmacists who prescribed and or filled drugs for that purpose would face criminal sanctions. This would lead to the revocation of their medical or pharmaceutical license to practice or dispense drugs. However, in 2006, the U.S. Supreme Court ruled that the "directive exceeded the powers of congress granted to the attorney general under CSA" with a 6-3 vote (Pew Research Center, 2006). They stated that the directive was both unlawful and unenforceable and therefore doctors and pharmacists could not be prevented from prescribing/filling prescriptions for lethal doses of drugs to terminal ill patients who qualify for PAS, without criminal sanctions.

Shortly following the *Gonzales v Oregon* ruling, Washington made PAS legal in 2008, followed by Montana in 2009, Vermont in 2013 and California in 2015. All of these court cases made national news and created a large amount of controversy which drew the public, politicians and law makers into the right-to-die debate. This also encouraged many Americans to look at end-of-life decisions so that should something happen to them they would be prepared.

Set Backs and Government Interference

In 1994 a U.S. District Judge, Michael Hogan, issued a temporary restraining order against Oregon's just passed ballot measure 16, which allowed PAS to be practiced in the state (Humphry, 2008). He then followed up the order with an injunction which barred the state from allowing the ballot to take effect. The following year Hogan ruled

stating Oregon's death with dignity act was unconstitutional as it violated the equal protection clause but was immediately overruled by a Ninth Circuit Court of Appeals and allowed for the act to take effect in 1995.

Two years after Oregon had begun practicing PAS, the House of Representatives and the Senate sent Ballot Measure 16 back to the state's voters for repeal despite their constituency's clear support and want of PAS. The voters once again voted to legalize PAS in obvious support of the act.

Two major setbacks for PAS came in 1997 with a U.S. Supreme Court ruling on two cases revolving around the prohibition of PAS by state laws. In *Vacco v. Quill* the court agreed with New York's anti- assisted suicide law, stating that it did not violate the equal protection clause. In the second case *Washington v. Glucksberg,* the court found there was no constitutional right to assisted suicide which was protected by the due processes clause. The court then discussed the legality of another end of life option, palliative care, and how when increased, can help bring the death to a suffering patient without legal consequences. The court went on to clarify the intent with which these measures were taken must be in an effort to help ease pain, not to outright cause death. The court closed out the hearing with a statement on how America was currently debating the morality and legality of PAS and will continue to in the coming years. While both Supreme Court cases were setbacks for PAS, they also allowed for the nation to view the issue on a much larger scale and spurred an increase in the right to die movement as Washington did go on to legalize PAS in 2008 along with several other states.

In 2004 the US president, President George Bush, and his administration asked the U.S. Supreme Court to ban Oregon's Death with Dignity Act, which was at the time

the only PAS law in place. The administration gave their reason for the request as PAS was not a legitimate medical practice and therefore could not be used; this was part of his campaign to become president as well. This request from the administration came about due to the previously mentioned U.S. Attorney General John Ashcroft, was appealing to the US Supreme Court to enforce the Ashcroft Directive. The Ashcroft Directive sought to use the federal government to penalize doctors and pharmacists who prescribed and filled drugs to PAS users, under the terms that PAS was not a recognized medical practice. Ultimately the Supreme Court ignored the President's request and found the Ashcroft Directive unconstitutional.

Recently in January of 2017 Congress attempted to block D.C.'s Death with Dignity Act when it was submitted for 30-day review, before taking effect. After D.C., had passed the bill through their council and the mayor had signed the bill in 2016, Congress members in both the US Senate and the House took advantage of their positions to try and pass resolutions, HJ RES 24/SJ Res 4, which denied the District of Columbia the right to legalize PAS. This fueled much anger from the residents of D.C. who claimed Congress had no right to use their federal powers to interfere with the passing of their PAS act as these senators did not represent the residents of D.C. (DeathwithDignity.org).

It is important to understand the fluid nature on what is considered a criminal act. As society continues to grow we encounter increasingly difficult situations, on what is or is not a crime. Oftentimes, there are circumstances when what is legally considered a crime does not have a straight forward approach, on how to handle many of the situations which could arise. Notable other examples include the public debate on drugs and on immigration. This give and pull on the legality of assisting someone in death has

followed the movement since its inception. If one looks at Washington, we see that assisted suicide was illegal for most of its time in the movement. With the state changing its stance, legally, on assisted suicide every year starting in 1993, until PAS was legalized in 2008. When looking closely at PAS laws one should notice that while PAS protects doctors and pharmacist who are aiding a patient, it does not protect anyone else. This means that while a doctor can assist a person in committing suicide, a husband cannot legally assist his terminal ill wife in dying. Such an act would be deemed homicide. However, when looking at cases where spouses are assisting each other in dying, the court system is murky. Legally speaking the person has committed a crime but in many cases the person, serves little to no time for the act. Two well-known examples of this are the cases of *Gilbert v State* and George Sanders. In 1986 76-year-old Roswell Gilbert shot his terminally ill wife, when her quality of life had diminished to her lowest point of acceptance. Following his wife's wishes he ended her life. He was sentenced to 25 years in a Florida prison but only served 5 years as he was granted clemency. His case caused a lot of debate in the state on whether the actions were morally acceptable, though many people sympathized with his actions, as they did not want a loved one to suffer unnecessarily. George Sanders is a recent case of an 86 year old man who shot and killed his wife in 2012. George's wife had been battling multiple sclerosis since 1969 and had recently taken a turn for the worst. George's own health was beginning to fail him, when his wife realized that her caregiver and life partner would not be able to continue caring for her much long. Facing amputations and a nursing home where she would have an extremely low quality of life, she asked her husband to end her suffering. The Arizona court understood the sensitive nature of the killing and commented on that while what he

did was a crime, he was the real victim of the case. He was sentenced to 2 years of unsupervised parole instead of 12 years in prison. When reviewing these two cases from a strictly legal perspective both men should have served the designated amount of prison time and would have, had they killed anyone else. However, since they were part of a group of people engaging in the mercy killings of already terminally ill patient, typically elders, who asked to be killed, there is a very difficult and fine line on the criminality of those actions.

End-of-Planning

When planning for end-of-life care there are several options open for one to express their medical wishes. While some will only vocalize their desires, a better alternative is to have an advance directive. Advance directives are documents, such as a living will or power of attorney, which allow a person to specifically state their end-of-life medical care inclinations for emergencies when they are unable to vocalize these wishes (Hopp, 2000). Advanced directives have only been in use since 1967, when the first living will was created by Louis Kuther (DeathwithDignity.org). Advanced directives were not extremely popular to start out with, in 1984. Seventeen years after the first living will was created, twenty-two U.S. states and the District of Columbia recognized advanced directives. By 1993 forty-eight states recognized advanced directives and one year later, in 1994, every state in the nation recognized advanced directives. Living wills are written instructions for specific medical care circumstances, such as in the case of a coma. For a more flexible arrangement there is the power of attorney, which is a legal document that has been filled out and signed beforehand appointing a trusted individual to make your medical decisions for you should you be

incapable of doing so. Advanced directives cannot however be used to administer PAS, in legal states, as death with dignity acts require patients to be of sound mind and body when asking for PAS. Patients must be able to fulfill the requirements of asking their attending physicians both verbally and in writing.

A 2009 Pew Research study, Growing Old in America: Expectations vs. Reality, found that older women, 66%, were more likely than older men, 52%, to have specifically discussed their medical wishes and end-of-life care with their children. Older whites, 66%, were also more likely to have spoken with their children regarding their medical wishes than older blacks, 56%, or older Hispanics, 41% (Pew Research Center, 2009).

When looking specifically at elders age 65 and older they generally have either a living will or have their wishes written down somewhere. A 2005 ageing survey found that elders 65 and older were more likely to have a living will, 54%, or have their end-of-life care written down, 51%, as compared to 36% of 50-64 year olds. (Pew Research Center, 2006). While these numbers are at about half of the surveyed elders reporting the use of advanced directives, past studies such as Hopp's 1995 study of 520 elders age 70 or older indicated that only 19.9% had advanced directive documents. However, 95% of these elders said that they had a person they trusted to make end-of-life decisions for them, with only 48.8% having actually spoken to the person about their wishes (Hopp, 2000). When looking purely at elder women a 2008 study of community dwelling elders, independently living, shows that of a sample of 220 women age 84-100, 55% of them have a living will, with 41% having both a proxy and a living will (McCarthy et al., 2008).

End-of-Life Care

End of life care has advanced hand and hand with the right to die movement. The right to die movement has spurred many patients' rights laws and has led to better management of terminal illness and pain in an attempt to stay away from PAS as an end of life option. In 1973, after the first death with dignity act was introduced to legislation, the American Hospital Association created the Patient Bill of Rights. These rights guaranteed a patient the right to informed consent on their medical diagnoses and practices as well as the right to refuse treatment. Then in 1974 the first hospice home care program came to America in New Haven, CT (Humphry, 2004). In 1990 the American Medical Association passed a proposition with which a doctor who has informed consent can withhold medical treatments from patients who are close to death and can withhold life support to patients in permeant comas (DeathwithDignity.org). The same year, Congress passed a Patient Self-Determination Act which forced and required all hospitals who received federal funding to inform their patients about their right to refuse and demand medical treatment or services. There are at the time two main, nationally available, end of life options, to ease the pain and suffering of the dying, with each offering extensive services, Palliative care and Hospice care.

Palliative care is specialized care for people who have serious but not necessarily fatal medical conditions or illnesses. Palliative care is used along with the patients' medical treatment in an attempt to provide quality of life, help manage physical symptoms and encourage the patient to have an optimistic view on how their treatment is progressing. Palliative care is available to a person of any age with any stage of serious

illness and provides services such as pain management, nausea, vomiting, constipation, diarrhea, fatigue and much more (GetPalliativeCare.org).

Hospice care is used for patients who only have six months left to live and aims to help keep a patient as comfortable as possible during their final days, until passing. Hospice does not actively try to bring death to a patient sooner than it naturally comes. The goal of hospice is to keep the patient comfortable through the use of medications, therapies and procedures as their illness takes over. Hospice can and is used when patients decide to stop medical treatment for an illness and are given six months or less to live. As hospice is the final step before death, it is normally conducted in the home, to give the patient as much peace and quality of life as possible. However, hospice is also provided in hospitals, nursing homes, and other advanced care facilities. This end of life care uses palliative care, in addition, as a way to help relieve pain, manage other physical and emotional issues as the patient and family wait for the end to come. According to the National Hospice and Palliative Care Organization 2015 report estimate, in 2014 there were 1.6-1.7 million patients who received hospice care, with 1,200,000 deaths across the nation. The majority of patients use hospice for 7-14 days before either dying or being discharged, 50.3%. Only 10.3% stayed in care for longer than 6 months. (National Hospice and Palliative Care Organization, 2015). The three most prominent age categories for participating patients is, 85+ at 41.1%, 75-84 at 26% and 65-74 with 16.8%. As women have a longer life expectancy than men, it should come as no surprise to find the majority of patients are women, 53%. Whites are the clear majority of participants with 76% of hospice recipients claiming it as their race. Since hospice is generally conducted in the home 58% received care and died in their own home.

Medicare covers 90% of the days spent receiving hospice and generally pays 85.5% of the cost of services.

While PAS is an end of life option it is still only available in the six select states and the District of Columbia. PAS offers those in hospice an easier alternative to dying at home by giving the patient one last freedom, to choose when they die. We can see from both Oregon and Washington's after death forms that the overwhelming majority of patients who took PAS were enrolled in hospice programs, 90% in Oregon and 81% in Washington (Public Health Division & Center for Health Statistics, Washington State Department of Health). This suggests patients are suffering to some degree while in hospice care, whether they are in pain, cannot stand their quality of life decreasing, or want to hasten their death some other way than with hospice care.

Elder Suicide

In recent years in the United States, researchers have begun to pay more attention to elder suicides, which has led to the increased awareness of its prevalence. American Prevention for Suicides estimates that in 2014, 1 in 4 elders who attempted suicide were successful (afsp.org). Elders' suicides tend to be successful since their bodies are older and have a harder time recovering from trauma. In 2013 the Center for Disease and Control estimated that there were 7,135 suicides in the 55-64yr age category alone, as suicide was the eighth leading cause of death for the age category (cdc.gov). The CDC went on to report 7,215 suicides for the 65-85+ age category, ranking as the seventeenth leading cause of death for elders (cdc.gov). A survey taken it that year showed that 62% of Americans believed it was acceptable to commit suicide if a person had no hope of improvement from their condition and were in great pain, while 56% of Americans

thought it was okay for a person with an incurable disease to commit suicide (Pew Research Center, 2013). In 2014 there was an increase in suicide related deaths for elders (65-85+ yrs. old) which pushed suicide to the sixteenth leading cause of death at 7,693 (cdc.gov). The 55-64 age category also experienced an increase in suicide, 7,527, but stayed in the eighth spot for leading causes of death. For 2015 suicide stayed as the sixteenth leading cause of deaths for elders but the number of suicides increased to 7,912 (cdc.gov). Again the 55-64 yr. old age group stayed in the eighth position but had an increased number of suicides, 7,739. The reasons for these events ranged from depression and mental health disorders, to the inability to live independently, doing things they once loved to do and feelings of being burdens to loved ones. While suicide is not covered under life insurance policies, it is ironic to find that in California, Colorado, Oregon, Vermont, Washington and D.C. patients who choose to participate in PAS are protected from losing their health or life insurance policies. This is because under the statues with which PAS was legalized, the use of PAS is a medical service and not classified as suicide.

Insurance, Health Care and Finances

Insurance coverage and health care options have long been at the center of controversy within the United States. Citizens worry about having too little coverage, too much, whether it is too privatized or if the government has too much say in the policies. This is a big issue for many of our country's elder population, since they rely on Medicaid, Medicare or other like programs for their medical coverage and needs. However, our population is continuing to age, meaning we are living longer and therefore have more elderly living who are dependent and need extra medical coverage for

medicines, end-of- life care and procedures. As our population ages, it puts a monetary strain on the health care system and causes a shortage of medical coverage, simply because the system is overwhelmed. To put this into perspective, elders (age 65 years and older) cost three to five times more in medical coverage than younger persons (Jacobzone & Oxley, 2001). As we continue to hold on to our elder population this spending continues to rise. States and legislature have tried to ease this problem by creating government based health care plans such as The Oregon Health Plan (OHP) and the federal Affordable Care Act, to name a few. The OHP quickly received an abundance of negative attention due to its seemingly stingy services. This plan often offered PAS to ill elderly patients, even though there were other medical options available, simply because it was less expensive. One such memorable case was the death of Barbara Wagner whose insurance told her they would not cover her cancer medicine and that PAS was the only option they would cover. She ended up living for another year before she died from her cancer. It is thought that many people other than Wagner were led to PAS by the OHP, simply because the state did not have to spend money to cover their medical needs. It did not matter if they were ready to give up and die. In an Oregon based study, 83% of physicians said they felt their patients were receiving PAS due to financial difficulties (Lee et al., 1996). This is a much higher number than one would have expected and causes a great deal of concern for the elder population. So, all of this leads to the compelling question of what people, particularly elders, actually think about PAS, or euthanasia. In the six states where PAS was legalized through act/bills or statutes it is up to the individual insurance providers whether or not they will cover the medical service of PAS. Any federally funded insurance provider such as Medicaid or Medicare cannot

cover PAS, service or medication, as PAS is not legal at the federal level (DeathwithDignity.org). Like insurance, it is up to licensed physicians, in those states, to decide if they will prescribe PAS drugs to qualified patients.

Opinions

There is little information specifically looking at elders' (65 and older) attitudes regarding euthanasia in general and PAS in particular. There is however, some amount of information about doctors, nurses and other health care professionals, along with terminally ill patients and their families', opinions on the subjects. In general, a recent PAS poll found 49% Americans to be against PAS laws (Pew Research Center, 2013). In the same study the only racial group to approve of PAS was Whites, 53%, with both Blacks and Hispanics sharing a 65% disapproval rating.

Terminally Ill Patients. In a Wilson et al. (2000) study done with terminally ill patients, the researchers found that 73% of responders believed that PAS or euthanasia should be legalized, while 58% of those patients believed that if it were legal, they would take this option. This is a very high number of participants who agree in theory and that would also choose either PAS or euthanasia. Yet it is easy to agree to something in theory but not agree to it personally or in life. The majority of the patients in the study cited their reason(s) for either choosing or supporting PAS or euthanasia, including seeing it as a last resort should the pain of their illness or disease become unbearable. Another study conducted by Emanuel, Fairclough & Emanual (2000) found that while patients would agree to PAS or euthanasia in a hypothetical situation (62%), only 10.6% individuals would consider it for themselves. The study also revealed that of the 10.6% of patients who would consider PAS or euthanasia for themselves, half of the group

changed their minds about a month later. Suarez-Almazor, Newman, Hanson & Bruera (2002) concluded the decisions to accept euthanasia by terminally ill patients is not based on the severity of the disease and its stage but is primarily determined by the patients' beliefs and psychosocial traits. Specifically, the researchers argued that an individual's personality, behavior types and beliefs have more influence than illnesses. So a person who is hard on themselves and believes they are a burden to their family by causing financial strain for medical bills can become depressed or anxious which may lead them to consider PAS. This is also supported by a study conducted in Oregon, which found that patients often gave a different reason other than pain or illness severity as their reason for PAS. Many of the patients said they felt as though they had lost a significant amount of autonomy, could not participate in life activities they once enjoyed and most importantly they were determined to control their own death (Sullivan, Hedberg & Fleming, 2000; Chin, Hedberg, Higginson & Fleming, 1999; Back, Wallace, Starks &Pearlman, 1996).

Caregivers and Families. In a 2000 study, researchers found that 58% of caregivers would support PAS and euthanasia as an option for their loved one, if said person was in a severe amount of pain from their illness (Emanuel et al., 2000). This shouldn't come as a surprise, since many people do not wish to see their loved ones experience a slow and painful death. However, what was surprising, was that 29% of responding caregivers, would support a loved one choosing PAS or euthanasia if they felt they were a burden, emotionally or financially, to their family (Emanuel et al., 2000).

Doctors, Nurses and Healthcare Professionals. The majority of surveys targeting doctors, nurses and health care professionals' opinions about PAS and

euthanasia have been conducted outside of the United States. These surveys tend to focus on euthanasia, hence why they are not conducted in the States, as euthanasia is not legal in any of the 50 states. Seale (2009) found doctors who had strong religious beliefs or were palliative care specialists, were generally opposed to legalizing PAS in the United Kingdom. It was notable that the doctors' opinions were the opposite of the UK's general public's opinion (Seale 2009). The majority of the public did support the legalization of PAS. Ward & Tate's (1994) survey conducted in the UK showed that doctors struggled to balance their religious beliefs with their professional beliefs and duties. There was a significant association between the religion and the opinion of not legalizing active euthanasia, while at the same time there was evidence suggesting doctors would practice active euthanasia, even if they held an opposing religious belief (Ward & Tate 1994). The influence of religion is that beliefs generally support the saving of lives and not the ending of them. For example, in Christian faiths, followers are taught not to kill, end lives or commit suicide, which may lead western doctors away from PAS. However, on the same note many faiths teach tolerance and mercy, with could influence a doctor to help a suffering patient end their life. In Lee et al.'s (1996) research, physicians in Oregon also had a hard time balancing their religious and moral beliefs with their professional ones, leading to 31% of responding physicians to opt not to participate in PAS. However, 46% cited that they would prescribe medication for PAS. One notable concern in this study was that the physicians themselves were worried about their abilities to accurately assess a patient's "six months" life expectancy. This was a concern since patients in Oregon must be assessed to have six months left to live in order to qualify for PAS. This is a valid concern, as it is the attending physicians' job to assess

the patients' quality of life left to live. It would be unfortunate to misdiagnose a patient as only having six months left to live when they have far more.

Religious Institutions. While many religious groups may proceed with the discontinuation of medical treatment when a patient has little to no chance of surviving, they do not support suicide. Religious groups often hold life to be sacred and will not condone acts of PAS or euthanasia. However, the doctrines of religious institutions do not condone the act of PAS, that is not to say their followers do as well. A striking example of this is the Catholic church, which is known for its pro-life beliefs. In a 2005 study 60% of catholic respondents agreed that a patient in great pain had the right to suicide. However, when asked if they would support PAS the approval rating dropped to 40%. The same group was also asked if they believed medical professionals should always do everything possible to save a patient's life. The overwhelming majority, 70%, disagreed and thought that there were special instances when a patient should be allowed to die (Pew Research Center, 2006). Similar results were shown in Protestant and secular religious denominations.

In a 2013 study done by the Pew Research Center, results showed support for committing suicide is extremely circumstantial with religious followers. Participants were given four scenarios in which to support a persons' moral right to end their own life: (1) when a person is in a great deal of pain, with no hope of improvement; (2) has an incurable disease; (3) is ready to die as living has become a burden; and (4) believe they are an extremely heavy burden on the family (Pew Research Center, 2013). The results showed that, going in the order listed, the first scenario had the most support and the last had the least. This happened in all five religions categorized: White Mainline Protestant,

White Catholic, Hispanic Catholic, White Evangelical Protestant and Black Protestant. White Mainline Protestants and White Catholics were the most supportive overall of the four circumstances, while White Evangelical Protestant and Black Protestants generally disapproved.

CHAPTER III

Methodology

While dying with dignity, the right to die and euthanasia are all widely-debated topics, existing research lacks a significant amount of information on elder's opinions of these topics. In turn, since the elderly are ostensibly the persons most likely to be personally affected by these practices, it is worth determining their opinions. More specifically, do their opinions differ from those of younger persons? In turn, based upon the potential influence of personal economics and religious factors, what may be the influence of socioeconomic status (S.E.S.) and other demographic factors upon these opinions? Due to the nature of the eight research questions and the need for age-specific identifiers, the Pew Research Center's (2005) Right-to-Die Survey was selected as the best source of data for answering these eight important questions. The survey provided both opinion and aging data about its respondents. Informed by the previously cited research, this analysis goes a step further by focusing on responses to those who are closer to their deaths than the population in general.

Research Questions

1. Are elders' opinions on the Physician Assisted Suicide different from those of younger adults?
2. How does race affect peoples' opinions on physician assisted suicide?
3. How does religion affect peoples' opinions on physician assisted suicide?
4. How does marital status affect peoples' opinions on physician assisted suicide?
5. How does gender affect peoples' opinions on physician assisted suicide?

6. How does the combination of age and race affect elders' opinions on physician assisted suicide?
7. How does the combination of age and religion affect elders' opinions on physician assisted suicide?
8. Does age and marital status affect the opinions of elders on physician assisted suicide?

Survey Data

The secondary data being examined in this study comes from The Right to Die Survey, which was sponsored by the Pew Research Center in 2005. The survey had a response rate of 30%, with a margin of error of ±2.8% (Pew Research Center, 2015). The sample was generated by Survey Sampling International, using list-assisted random digit dialing in order to gather an unbiased nationwide sample of landline based telephone numbers (Pew Research Center, 2015). The numbers were cross-checked with all known businesses and those with matching numbers were eliminated from the sample, resulting in 10,776 eligible numbers. The population telephone numbers were then handed off to Princeton Data Source to conduct the actual interviews. The company found that only 5,890 numbers working and of that 4,596 numbers were actually contacted, meaning a person picked up the phone to respond. Only 1,848 of these 4,596 telephone numbers chose to participate in the interview survey. Of these, 1,568 persons contacted spoke English and had an adult available to take the survey in the household. There were then 68 phone calls which were interrupted or canceled, giving a total of 1,500 completed surveys from adults, ages 18 years and older, between November 9 and November 27, 2005. The current study then uses a segment of the original interviewers for the final

sample size. This happened as a result of the dependent variable (PAS question “In some states, it's legal for doctors to prescribe lethal doses of drugs that a terminally ill patient could use themselves to commit suicide. Do you approve or disapprove of laws that let doctors assist patients who want to end their lives this way?”) only being asked on form 2 of the survey. This substantially cut the sample size from 1,500 to 752, with the final sample size consisting of 690 participants. There were several questions throughout the survey where the original researchers only presented a variable on one form, but there was not an explanation given as to why. This survey collected information about a variety of sociodemographic factors as well as asked for opinions regarding end of life care, advanced directives and thoughts on when death/suicide is an option. The survey is publicly available with the download of the data set on the Pew Research Center’s website.

There are a few weaknesses in the collection of the original data set which will in turn affect the current study. One is that the survey was only conducted with houses which had a telephone (landline). By excluding houses which used cell phones as their home phone or houses that had no form of telecommunication the survey has left out a segment of the nation’s population. Also, the entire survey was written and conducted in English. This leaves out many of the first-generation family members of immigrants who have not learned English well enough to have full English-only conversations. While this survey was supposed to be conducted across the entire nation, the survey was actually only conducted in the continental United States. The continental United States is comprised of 48 states; thus, there are no respondents from Alaska, Hawaii and U.S.

Territories (Pew Research Center, 2010). These three factors decrease the generalizability of the survey to the entire United States population.

Findings from Original Study

The original Right to Die Survey gathered data for researchers to use in a 2005 paper called "Strong Public Support for Right to Die". This report compared two data sets which were collected using the same survey instrument. The first set of data was collected in 1990, while the second was collected in 2005 (Pew Research Center, 2006). It is important to note that the same people were not specifically contacted to participate in the second survey as this was not a longitudinal study following the same people over the course of 15 years. The researchers examined the two sets of data to determine how public attitudes on the right to die and end of life issues were changing in the nation. Their research found that support for right to die laws had increase from 79% in 1990 to 84% in 2005. However, when survey responders where asked if they felt patients should sometimes be allowed to die (without specifying a legitimate medical reason), support for these laws decreased from 73% (1990) to 70% (2005). Responders were also asked if a doctor should always try to save a patient's life. Affirmative responses to this question increased from 15% in 1990 to 22% in 2005. It is interesting to see how a change in wording affects respondents' answers on virtually the same topic. The majority of respondents in both survey samples agreed that a family member had the right to cancel or continue medical treatment, in place of a patient, as long as the patient is terminally ill (71% in 1990 and 74% in 2005). In this case the patient is completely unable to communicate and must rely on their family members or legal guardians to make decisions regarding their end of life care. When respondents were asked to apply the act

of “mercy killing” to a terminally ill spouse, 61% of respondents agreed that the act was either “always” justified or was “sometimes” justified. It would seem that in terms of having to watch a loved one suffer, the respondents would rather let them die on their own terms than experience a slow agonizing death. However, when asked on the moral right of a person to end their own life due to feelings of being a burden, instead of a terminal illness, 62% of respondents disagreed that they had the right to commit suicide. An important note was the limited racial/ethnicity categories in the original surveys and the 2005 report. The researchers only included four racial categories white, non-white, black and Hispanic. They had also limited the data by excluding multiple racial ethnicities in the survey. The researchers also did very little concerning the elder population, as age was only examined alone or paired with sex, whereas it could have been paired with religion or political affiliation.

Further Publications

The Pew Research Center published a 2009 report looking into end of life decisions from the 2005 data set. The study showed elders, 51%, were more likely to put into writing what their end of life medical treatment wishes were than any other age group (Pew Research Center, 2009). The study showed the majority of Americans with grown children have discussed their end of life wishes with their children. This included speaking about having a will, how to manage medical care should a decision have to be made for them and even what do do should the parent lose their ability to live independently. When asked if they approved of laws which allowed terminally ill patients to stop medical treatment, an astounding 84% of the participants agreed.

So far, with the exception of the current study, these are the only two studies that have used the 2005 Aging data set. The other previously mentioned Pew Research studies, in a literature review, all collected new data to analyze and compared it to the previous findings in their original 2005 published work.

Variables and Data Analysis

Using descriptive statistics and Chi Square statistics to analyze and test the relationships between variables, the present study attempts to answer the eight, previously stated, research questions. While the entire survey has a little over 44 questions, there were 22 questions which related to the subjects of right-to-die, dying with dignity, PAS or euthanasia; with one question specifically naming PAS. The PAS question "In some states, it's legal for doctors to prescribe lethal doses of drugs that a terminally ill patient could use themselves to commit suicide. Do you approve or disapprove of laws that let doctors assist patients who want to end their lives this way?" was used as the dependent variable. Independent variables of specific interest are the socio-demographic variables such as age, sex, marital status, race and religion. All variables with the exception of age were measured at the nominal level; age was measured at the ordinal level.

The data set was cleaned by deleting all variables which were irrelevant to the present study. After removing inessential variables, the study was left with seven variables; age, race, religion, sex, marital status, Q9f2 (PAS question) and form (survey form 1 or form 2). As only participants who, randomly, received Form 2 were asked the question regarding PAS, all Form 1 participants were deleted from the data set. In addition, there were 62 people who were deleted from the data set who did not answer the

PAS question. The variable age had a range of individual ages from age 18 to 97+. Age was recoded into four age groups to allow the study to view trends within the data set. The variables marital status, religion and race were all recoded to treat the response of do not know/refused to answer as missing and is listed in its own category. For the religion variable, the categories of Islam/Muslim, Greek Orthodox (Greek or Russian), and Mormon (Including The Church of Jesus Christ of Latter Day Saints) were all recoded to part of the "other religion" category. This was done as the three categories did not have sufficient numbers to be their own categories and as the survey sample was already small, it was prudent to keep as many eligible participants as possible. Finally, for the marital status variables the categories of divorced, separated and widowed were all recoded and combined together. This was once again done as the categories did not have enough participants to be their own individual categories.

Chi square statistics were used to test bivariate and multivariate relationships. First age, race, religion, marital status and gender were all tested on the dependent PAS variable using chi squared tests of independence. The bivariate relationships were tested first in order to gather information on how each variable affected a person's opinion on PAS, if at all. One cannot conduct a multivariate analysis without first knowing how the individual variables will affect the dependent variable. Lastly the age variable was added to race, marital status and religion for multivariate analysis using chi square statistics.

Weaknesses in Methodology

There are a few weaknesses in the methodology used for this study. First this study is using secondary data. While using secondary data is economical, due to the time and money it saves researchers, it also presents several problems. The quality of the

work going into collecting the data is unknown, as you are not the primary researcher conducting the interviews.

Secondly, secondary data was originally collected with a specific question or set of questions in mind, which the researchers seek an answer to. By using secondary data, which was originally collected to gain insight on the opinions of right to die laws, other studies are limited to the variety of questions and applications that can applied to the data. As PAS is a specialized area of right to die, which was covered in the survey, this data set was applicable to the present study. That being said, the original study was not designed to focus on the opinions of elders but rather the opinions of the general population across the United States. There was not a data set available which focused solely on the opinions of elders on PAS; therefore, a data set that was the best fit was applied. However, PAS was only specifically mentioned in one survey question, which appeared on the Form 2 survey. While the forms were randomly given to the interviewees, there were a few questions which were only present on a single form of the survey. It is not known why the original researchers did this on select questions. Nonetheless it presented a problem for the current study as it cut the eligible survey population down.

There were several weaknesses and limitations applied to the current study as chi squared tests of independence were used to test the relationships between the variables. While chi squared tests of independence does show if there is an association between the variables, but as this study does not truly do multivariate analysis, there are other variables which could influence results. Therefore, future testing would be needed to look at the interactions found by the study. Chi square statistics is also very sensitive to small sample sizes and cell counts whose expected frequency is less than 5. Due to low cell

numbers in the religious categories of Mormon, Islam/Muslim and Orthodox the three had to be recoded and included in the other religion category, to meet the requirements of running the analysis.

CHAPTER IV

Results

Descriptive Analysis

This analysis included a total of 690 participants with a minimum age of 18 and a maximum age of 99 years old. As seen in Table 1 more participants were in the 35 to 50 age group (n = 205, 29.7%), followed by the 51 to 65 age group (n = 176, 25.5%). Race was reported as White (*n* = 569, 82.5%), Black (*n* = 68, 9.9%), Asian (*n* = 10, 1.4%), Mixed Race (*n* = 35, 5.1%). For Religion, most were Protestant (*n* = 371, 53.8%) followed by Roman Catholic (*n* = 147, 21.3%). The majority of the participants reported being "married" (*n* = 373, 54.1%) followed by "Divorced/Separated/Widowed" (*n* = 156, 22.6%). More participants reported being female (*n* = 389, 56.4%) than male (*n* = 301, 43.6%). Finally, on PAS, most of the participants who were asked the question approved of PAS (n = 351, 50.9%%).

In cases where a participant gave an answer of "I do not know" or gave an answer of "refused to answer the question" but did not skip the question or hang up they were placed in the "missing" category for the variable.

Table 1

Demographics

		Frequency	Percent
Age	35 or younger	160	23.2
	35 to 50	205	29.7
	51 to 65	176	25.5
	66 or older	149	21.6
	Total	690	100.0

(continued)

		Frequency	Percent
Race	White	569	82.5
	Black	68	9.9
	Asian	10	1.4
	Other or Mixed race	35	5.1
	Missing	8	1.2
	Total	690	100.0
Religion	Protestant (Including Baptist, Lutheran, Methodist and Presbyterian)	371	53.8
	Roman Catholic	147	21.3
	Jewish	17	2.5
	Other religion (including Mormon, Church of Jesus Christ of Latter Day Saints, Islam/Muslim and Orthodox Church)	49	7.1
	No religion, not a believer, Atheist, Agnostic	82	11.9
	Missing	24	3.5
	Total	690	100.0
Marital Status	Married	373	54.1
	Living with a partner	36	5.2
	Divorced, Separated or Widowed	156	22.6
	Never been Married	117	17.0
	Missing	8	1.2
	Total	690	100.0

(continued)

		Frequency	Percent
Gender	Male	301	43.6
	Female	389	56.4
	Total	690	100.0
PAS	Approve	351	50.9
	Disapprove	339	49.1
	Total	690	100.0

Research Questions

Are elders' opinions on the Physician Assisted Suicide different from those of younger adults? . The variable of Age was in categories which made it an ordinal variable and Physician Assisted Suicide (PAS) was nominal (Approve or Disapprove). When the dependent variable is nominal this limits the types of statistics that can be done. A Chi-Square Test of Independence can indicate if there is a relationship that exists between the two variables (Freedman, Pisani & Purves, 2011). As seen in Table 2, there was not a significant relationship between Age and PAS Responses ($X^2(3) = 6.534$, $p = 0.088$). Persons 50 and younger were more likely to approve of PAS whereas persons 66 and older were the only category to disapprove of PAS, 57%. It was interesting to note the 51-65 age category acted as the middle ground for PAS. This group was split down the middle on their opinion of PAS. This could be an indication of middle age being the buffer zone or decision making, as the person is not considered young nor necessarily old. As this study had a specific interest in age, the variable was looked at in a broader sense, to gain insight on the trends with in the data set. As seen in table 3, when collapsing the age variable to two categories, there is a significant relationship between age and PAS Responses ($X^2(1) = 4.133$, $p = 0.042$). Persons 50 and younger were more

likely to approve of PAS (54.5%), whereas persons 51 and older were more likely to disapprove of PAS (53.2%).

Table 2

Age and PAS Chi-Square

		Approve		Disapprove		
		Frequency	Percent	Frequency	Percent	Total
Age	35 or younger	83	51.9	77	48.1	160
	35 to 50	116	56.6	89	43.4	205
	51 to 65	88	50.0	88	50.0	176
	66 or older	64	43.0	85	57.0	149
Total		351	50.9	339	49.1	690

Table 3

Age and PAS Chi-Square

		Approve		Disapprove		
		Frequency	Percent	Frequency	Percent	Total
Age	50 or younger	199	54.5	166	45.5	365
	51 or older	152	46.8	173	53.2	325
Total		351	50.9	339	49.1	690

How does gender affect peoples' opinions on physician assisted suicide? The variable of Gender was in categories which made it a nominal variable and Physician Assisted Suicide (PAS) was nominal (Approve or Disapprove). As seen in Table 4, there

was not a statistically significant relationship between Gender and PAS Responses (X^2 (1) = 2.792, p = 0.095). Males tended to support PAS (54.5%), while females disapproved of PAS (51.9%). While there were more females than males, the female group did seem torn on whether to support or disapprove of PAS, with 3.8% more disapproving. This was consistent with previous findings in the literature review with both approval of PAS and the willingness to take PAS as an end of life option.

Table 4

Gender and PAS

		Approve		Disapprove		
		Frequency	Percent	Frequency	Percept	Total
Gender	Male	164	54.5	137	45.5	301
	Female	187	48.1	202	51.9	389
Total		351	50.9	339	49.1	690

How does race affect peoples' opinions on physician assisted suicide? The variable of Race was in categories which made it a nominal variable and Physician Assisted Suicide (PAS) was nominal (Approve or Disapprove). As seen in Table 5, there was a statistically significant relationship between Race and PAS Responses (X^2 (4) = 20.785, $p < 0.001$). Consistent with the findings of a 2013 Pew Research Center study, Blacks were more likely to disapprove of PAS (75%), whereas whites were more likely to approve (54%). Asians supported PAS (60%), while persons of mixed race showed slightly more disapproval than acceptance of PAS. It is important to note within the mixed-race category there were 17 people who approved and 18 people who disapproved.

With only one more person in the disapprove category, the findings likely could have gone either way due to the small number of participants who claim Asian as their race. The same could be said for the Asian category as well, with six persons approving and four disapproving. This category had two more people who approved than disapproved. Categories of Asian and Mixed race need to be looked at with a larger number of participants in these categories. For race, there were eight individuals who refused to answer their race or did not know; these individuals were treated as missing in the analysis and given their own category.

Table 5

Race and PAS

		Approve		Disapprove		
		Frequency	Percent	Frequency	Percent	Total
Race	White	307	54.0	262	46.0	569
	Black	17	25.0	51	75.0	68
	Asian	6	60.0	4	40.0	10
	Other or mixed race	17	48.6	18	51.4	35
	Missing	4	50.0	4	50.0	8
Total		351	50.9	339	49.1	690

How does religion affect peoples' opinions on physician assisted suicide? The variable of Religion was in categories which made it a nominal variable and Physician Assisted Suicide (PAS) was nominal (Approve or Disapprove). As seen in Table 6, there

was a statistically significant relationship between Religion and PAS Responses ($X^2(5) = 26.552$, $p < 0.001$). Atheists/Agnostics (72%), Jewish (76.5%) and those who were categorized as other religion (51%) were more likely to approve of PAS. Catholics (55.10%) and Protestants (53.6%) were the only two categories of religion to disapprove of PAS. It is interesting but perhaps not surprising that the two Christian religions would hold the same opinion on PAS. The religious category of "other religion" was composed of followers from Mormonism, Islam/Muslim, Greek/Russian Orthodox church, as well as participants who did not have a religion which fit into any of the available categories such as Buddhism or Hinduism. As stated earlier this was done due to the low number of participants in the three categories and rather than remove them from an already shrinking sample they were recoded to be included in the other category. The other category does favor PAS (51%) but only by one person. In a larger sample with evenly distributed religious categories it would be interesting to see where the three religions and the other category would fall. Due to the number of religions included in the other category, at this time, few inferences can be made as there are too many factors. There were 24 persons who gave an answer of "I do not know" or "refuse to answer" on the variable of religion, as stated these responses are treated as missing and are given their own category for the analysis.

Table 6

Religion and PAS

		Approve		Disapprove		
		Frequency	Percent	Frequency	Percent	Total
Religion	Protestant (include Baptist, Lutheran, Methodist and Presbyterian)	172	46.4	199	53.6	371
	Roman Catholic	66	44.9	81	55.1	147
	Jewish	13	76.5	4	23.5	17
	Other religion (include Mormon, Church of Jesus Christ of Latter Day Saints, Islam/Muslim and Orthodox Church)	25	51.0	24	49.0	49
	No religion, not a believer, Atheist, Agnostic	59	72.0	23	28.0	82
	Missing	16	66.7	8	33.3	24
Total		351	50.9	339	49.1	690

How does marital status affect peoples' opinions on physician assisted suicide? The variable of Marital Status was in categories which made it a nominal variable and Physician Assisted Suicide (PAS) was nominal (Approve or Disapprove). As seen in Table 7, there was a statistically significant relationship between Marital Status and PAS Responses ($X^2(4) = 11.977$, $p = 0.018$). People living with a partner (72.2%) and those who had never been married (55.6%) were more likely to support PAS. Those who are divorced/separated/widowed (57.1%) were more likely to disapprove of PAS. People who were married (50.4%) generally supported PAS. While

people who claimed they were married did support PAS, it was by three people. This category would need to be looked at with a larger and proportionate sample to truly gain insight into the findings. There were also eight people who were in the missing category, as they not give their marital status.

Table 7

Marital Status and PAS

		Approve		Disapprove		
		Frequency	Percent	Frequency	Percent	Total
Marital Status	Married	188	50.4	185	49.6	373
	Living with a partner	26	72.2	10	27.8	36
	Divorced, Separated or Widowed	67	42.9	89	57.1	156
	Never been married	65	55.6	52	44.4	117
	Missing	5	62.5	3	37.5	8
Total		351	50.9	339	49.1	690

How does the combination of age and religion affect elders' opinions on physician assisted suicide? The variable of Age and Religion were in categories which made them categorical variables and Physician Assisted Suicide (PAS) was nominal (Approve or Disapprove). As seen in Table 8, when controlling for religion, there was not an interaction effect between Age and PAS Response for the religions of Protestantism ($X^2(3) = 2.074$, $p = 0.557$), Age and Other Religion with PAS Responses

($X^2(3) = 4.612$, $p = 0.203$) and Age and Atheist/Agnostic with PAS Responses ($X^2(3) = 4.587$, $p = 0.205$). There was an interaction effect found between Age and PAS Response for Catholicism ($X^2(3) = 7.928$, $p = 0.048$) and Judaism ($X^2(3) = 7.969$, $p = 0.047$). As age increased, Catholics were more likely to disapprove of PAS (55.10%), whereas for Jewish followers, as age increased there was a higher likelihood of supporting PAS (76.5%). When looking closer at the Roman Catholic category, we find for the age ranges of 35-50 (58.7%) and 35 and younger (52%) there was a general acceptance of PAS. It is important to look at the number of participants who were in the youngest age bracket as there was only a difference of one person between the approval and disapproval groups. The age bracket of 51-65 (69.4%) and 66+ (62.5%) disapproved, with the younger of the two having a stronger dislike of PAS. When looking at the Jewish category one should realize that while there was a significant interaction effect between age and PAS the number of participants was only 17. This left two of the age brackets having a 100% approval and disapproval rating, when in reality there was only two (35-50) and three (66+) people in those age ranges. While there were significant findings for this variable, it should be taken with caution, as when tested with a larger sample, the interaction between the variables could disappear. Protestants were the only category to continuously show disapproval in all age brackets, with the 66+ group showing the majority of disapproval (60.2%). The other religion and no religion categories both showed approval in all age ranges. For other religion, the highest approval age range was the 35-50 group at 66.7%. The no religion group with the highest approval was 51-65 at 90%, but that age range only had 10 people in it.

Table 8

Age and Religion by PAS

Religion	Age	Approve		Disapprove		Total
		Frequency	Percent	Frequency	Percent	
Protestant (including Baptist, Lutheran, Methodist and Presbyterian)	35 or younger	34	47.2	38	52.8	72
	35 to 50	50	48.5	53	51.5	103
	51 to 65	53	49.1	55	50.9	108
	66 or older	35	39.8	53	60.2	88
	Total	172	46.4	199	53.6	371
Roman Catholic	35 or younger	13	52.0	12	48.0	25
	35 to 50	27	58.7	19	41.3	46
	51 to 65	11	30.6	25	69.4	36
	66 or older	15	37.5	25	62.5	40
	Total	66	44.9	81	55.1	147
Jewish	35 or younger	3	75.0	1	25.0	4
	35 to 50	0	0.0	2	100.0	2
	51 to 65	7	87.5	1	12.5	8
	66 or older	3	100.0	0	0.0	3
	Total	13	76.5	4	23.5	17
Other religion (include Mormon, Church of Jesus Christ of Latter Day Saints, Islam/Muslim and Orthodox Church)	35 or younger	9	52.9	8	47.1	17
	35 to 50	12	66.7	6	33.3	18
	51 to 65	2	28.6	5	71.4	7
	66 or older	2	28.6	5	71.4	7
	Total	25	51.0	24	49.0	49

(continued)

Religion	Age	Approve		Disapprove		Total
		Frequency	Percent	Frequency	Percent	
No religion, not a believer, Atheist, Agonist	35 or younger	22	61.1	14	38.9	36
	35 to 50	22	75.9	7	24.1	29
	51 to 65	9	90.0	1	10.0	10
	66 or older	6	85.7	1	14.3	7
	Total	59	72.0	23	28.0	82
Missing	35 or younger	2	33.3	4	66.7	6
	35 to 50	5	71.4	2	28.6	7
	51 to 65	6	85.7	1	14.3	7
	66 or older	3	75.0	1	25.0	4
	Total	16	66.7	8	33.3	24
Total	35 or younger	83	51.9	77	48.1	160
	35 to 50	116	56.6	89	43.3	205
	51 to 65	88	50.0	88	50.0	176
	66 or older	64	43.0	85	57.0	149
	Total	351	50.9	339	49.1	690

How does the combination of age and race affect elders' opinions on Physician Assisted Suicide? The variable of Age and Race were in categories, which made them categorical variables and Physician Assisted Suicide (PAS) was nominal (Approve or Disapprove). As seen in Table 9, when controlling for race, there was no interaction effect found between Age and PAS Responses for the racial categories of White ($X^2(3) = 4.270$, $p = 0.234$), Black ($X^2(3) = 3.914$, $p = 0.271$), Asian ($X^2(3) = 2.708$, $p = 0.439$) and Other/mixed race ($X^2(3) = 7.187$, $p = 0.066$). As race and PAS was found to have a significant relationship, it was disappointing to see when age was

combined that there was not an interaction effect found. Blacks overwhelmingly disagreed with PAS in all age categories (75%). Whites approved of PAS in the 65 and younger age ranges by over 53% in each group. The 66+ age range for whites had a 53% disapproval rating. As the Asian category had a 60% approval rating, few conclusions can be drawn from the findings as all of the age ranges had three or less participants on PAS question. Few inferences can be drawn from the mixed-race category as well due to low participant numbers in each of the age ranges. The 51-65 and 65+ had 100% disapproval ratings but only had 3 participants each.

Table 9

Age and Race by PAS

		Approve		Disapprove		
Race	Age	Frequency	Percent	Frequency	Percent	Total
White	35 or younger	63	56.3	49	43.8	112
	35 to 50	100	58.5	71	41.5	171
	51 to 65	82	53.2	72	46.8	154
	66 or older	62	47.0	70	53.0	132
	Total	307	54.0	262	46.0	569
Black	35 or younger	8	29.6	19	70.4	27
	35 to 50	4	28.6	10	71.4	14
	51 to 65	5	29.4	12	70.6	17
	66 or older	0	0.0	10	100	10
	Total	17	25.0	51	75.0	68
Asian	35 or younger	3	75.0	1	25.0	4
	35 to 50	2	50.0	2	50.0	4
	51 to 65	1	100.0	0	0.0	1

(continued)

		Approve		Disapprove		
Race	Age	Frequency	Percent	Frequency	Percent	Total
	66 or older	0	0.0	1	100.0	1
	Total	6	60.0	4	40.0	10
Other or mixed race	35 or younger	8	53.3	7	46.7	15
	35 to 50	9	64.3	5	35.7	14
	51 to 65	0	0.0	3	100.0	3
	66 or older	0	0.0	3	100.0	3
	Total	17	48.6	18	51.4	35
Missing	35 or younger	1	50.0	1	50.0	2
	35 to 50	1	50.0	1	50.0	2
	51 to 65	0	0.0	1	100.0	1
	66 or older	2	66.7	1	33.3	3
	Total	4	50.0	4	50.0	8
Total	35 or younger	83	51.9	77	48.1	160
	35 to 50	116	56.6	89	43.4	205
	51 to 65	88	50.0	88	50.0	176
	66 or older	64	43.0	85	57.0	149
	Total	351	50.9	339	49.1	690

Does age and marital status affect the opinions of elders on physician assisted suicide? The variable of Age and Marital Status were in categories which made them categorical variables and Physician Assisted Suicide (PAS) was nominal (Approve or Disapprove). As seen in Table 10, when controlling for marital status there was no interaction effect found between Age and PAS Responses for the categories of Married ($X^2(3) = .625$, $p = 0.891$), Living with a Partner ($X^2(3) = 1.253$, $p = 0.740$), Divorced/Separated/Widowed ($X^2(3) = 4.975$, $p = 0.174$), and Never Been Married ($X^2(3) = 3.117$, $p = 0.374$). As marital status and PAS showed a significant relationship in

the bivariate analysis, it was disappointing to find when the two are combined with age that not an interaction effect found at the multivariate level. All of the age groups for the variables of the living with a partner and never been married agreed with PAS, with the exception of N.B.M's 51-65 age category which was split 50/50.

Table 10

Age and Marital Status by PAS

		Approve		Disapprove		
Marital Status	Age	Frequency	Percent	Frequency	Percent	Total
Married	35 or younger	29	48.3	31	51.7	60
	35 to 50	71	52.2	65	47.8	136
	51 to 65	56	51.4	53	48.6	209
	66 or older	32	47.1	36	52.9	68
	Total	188	50.4	185	49.6	373
Living with a partner	35 or younger	8	66.7	4	33.3	12
	35 to 50	13	81.3	3	18.8	16
	51 to 65	3	60.0	2	40.0	5
	66 or older	2	66.7	1	33.3	3
	Total	26	72.2	10	27.8	36
Divorced, Separated or Widowed	35 or younger	8	57.1	6	42.9	14
	35 to 50	19	52.8	17	47.2	36
	51 to 65	19	44.2	24	55.8	43
	66 or older	21	33.3	42	66.7	63
	Total	67	42.9	89	57.1	156
Never been married	35 or younger	38	52.1	35	47.9	73
	35 to 50	12	75.0	4	25.0	16
	51 to 65	9	50.0	9	50.0	18
	66 or older	6	60.0	4	40.0	10

(continued)

		Approve		Disapprove		
Marital Status	Age	Frequency	Percent	Frequency	Percent	Total
	Total	65	55.6	52	44.4	117
Missing	35 or younger	0	0.0	1	100.0	1
	35 to 50	1	100.0	0	0.0	1
	51 to 65	1	100.0	0	0.0	1
	66 or older	3	60.0	2	40.0	5
	Total	5	62.5	3	37.5	8
Total	35 or younger	83	51.0	77	48.1	160
	35 to 50	116	56.6	89	43.4	205
	51 to 66	88	50.0	88	50.0	176
	66 or older	64	43.0	85	57.0	149
	Total	351	50.9	339	49.1	690

CHAPTER V

Conclusion and Recommendations

Given that the elder segment of the United States' population will soon account for 20% of our overall population, the opinions and welfare of our elders has become increasingly important. This has led to the resurgence of interest in Right to Die laws. With six U.S. states and the District of Columbia having passed right to die laws, which allow physician assisted suicide to be used in specific circumstances, the need for elders' opinions on the matter arose. This exploratory study has looked into what sociodemographic factors, specifically the increase of age, affect elders' opinions on physician assisted suicide.

This study used a 2005 Right to Die data set collected by the Pew Research Center. The data set was collected from November 9th through December 27th in 2005, via telephone interviews. The Princeton Data Source conducted random digit dialing interviews with landline based home phones inside the continental United States. While there were an initial 10,766 phone numbers dialed, there was only 1,500 completed interviews. In an attempt to retrieve a variety of ages for the survey, researches asked to speak with the youngest male of 18 years of age, followed by the youngest female, should a male not be available. The original intent of the survey was to compare the results of this data set to a previously conducted data set from 1990, in an effort to determine how public attitudes towards the right to die and end of life issues was changing.

This study tested these eight research questions, geared to analyze the affects that age, race, marital status, gender, religion has on the opinions of physician assisted suicide:

1. Are elders' opinions on the Physician Assisted Suicide different from those of younger adults?
2. How does the combination of age and race affect elders' opinions on physician assisted suicide?
3. How does the combination of age and religion affect elders' opinions on physician assisted suicide?
4. Does age and marital status affect the opinions of elders on physician assisted suicide?
5. How does race affect peoples' opinions on physician assisted suicide?
6. How does religion affect peoples' opinions on physician assisted suicide?
7. How does marital status affect peoples' opinions on physician assisted suicide?
8. How does gender affect peoples' opinions on physician assisted suicide?

Using descriptive statistics and Chi Square statistics to test and analyze the relationship between the variables, this study has found some significance within the variables.

When testing the bivariate relationships, it was disappointing to find that within this data set there was not a significant relationship between age and a persons' opinion on physician assisted suicide when breaking the age categories into four groups. In this sample, there was approval for PAS from persons 50 and younger, while those in the age

category of 51-65 were split 50/50 on whether to approve or disapprove of PAS. The age category of 66 and older had a 7% greater disapproval rating on PAS. However, when age was reduced to two categories there was a significant relationship found at the 0.05 significance level. Persons 50 and younger were more likely to approve, 54.5%, PAS than those who were older. There were significant findings for race, religion and marital status at the bivariate level, while the only combination of variables with age which had significance was religion. Race had a significant effect on the approval or disapproval of PAS at the 0.01 level. There was an interesting disparity between three of the races regarding approval rating. Whites generally approved of PAS, 54%, with Asians having the largest approval at 60%, while only one third of Blacks approved of PAS. This matches Oregon's and Washington's reports, on their PAS participants, showing the majority of people using PAS are Whites (Public Health Division & Center for Health Statistics, Washington State Department of Health). However, when controlling for race there was no significant interaction between age and PAS responses. Interestingly, in the all four age groups for Blacks the disapproval rating was 70% and over, while the White age groups 35 and younger to 65 years old had at least a 53% approval rating. It was interesting to see the oldest grouping of Whites, 66 years and older, had a 53% disapproval rating of PAS, while up until now they seemed to approve of it as they aged. Religion had a significant effect on PAS by its self and when controlled for showed an interaction effect between Age and PAS responses. At the bivariate level religion had a significance level of 0.01 on the approval or disapproval of PAS. Atheists/Agnostics (72%) and Jewish (76.5%) followers had an overwhelming approval rating for PAS. Not surprisingly Roman Catholics (55.10%) and Protestants (53.6%) tended to disapprove. It

was interesting to see how close to being a split decision the two were, especially the Roman Catholic population of this sample. One might have thought there would be an overwhelming disapproval rating from the two. When religion was controlled for, there were two significant interaction effects found between Age and PAS responses at the 0.05 level. First, as Catholics aged their disapproval of PAS increased. Catholics ages 18-50 were at least 52% in favor of PAS while Catholics ages 51 and older were at least 62% against PAS. This could be due to the increased presence of elders' participation in the Catholic church as they age. The second significant finding was that as Jewish followers aged they had an increased acceptance of PAS. Jewish followers ages 18-35 had a 75% approval rating while ages 51 and older had an 87% approval rating. The last finding of significance was at the bivariate level with Marital Status and PAS. Those who had been divorced, separated or widowed had a 57.1% disapproval rating on PAS. Meanwhile people who had never been married or were living with a partner had a combined approval rating of 59.4%. These were interesting findings as we know from both Oregon and Washington that the majority of participants of PAS are married, 45% for all participants in Oregon and 47% for Washington in the year 2015 (Public Health Division & Center for Health Statistics, Washington State Department of Health).

These findings contribute to the national debate on physician assisted suicide, right to die laws and end of life care. As our nation's elder population continues to grow our health care system is continuing to be stressed, as end of life care is being used more often and gaining more attention. While there have been advancements in the treating and managing of end of life issues such as pain, loss of autonomy and care in general, there is still much to be done. Palliative and hospice care can only do so much to ease the pain of

terminally ill patients before their death. While PAS, euthanasia and end of life care have all been around in the legal debate for a while, it is important to note that each of these have in turn spurred the advancement of the other. Through the debates, state law and supreme court rulings of acceptable end of life care, terms and conditions to legally discontinuing life-sustaining technology on a brain-dead person, the acceptance of a brain-dead person as legally dead, when to allow PAS and under what conditions and much more, we have developed numerous patients' rights which are recognized across the nation, have made advancements in hospice and palliative care treatments and more. The right to die debate has undoubtedly been an extremely controversial debate since it was first introduced into the United States legislation in 1967. Like hospice, PAS allows for terminally ill patients with six months left to live to die in the comfort of their own home, PAS goes a step further by allowing the terminally ill and already dying patient to decide when the time to die is right for them. This allows the patient to say their goodbyes, avoid unnecessary pain and to not suffer through the indignities of losing one's autonomy. Part of having a quality of life is still being able to do things you once loved, being able to take care of yourself, not to be bedridden and dependent. As we know from Oregon's after death forms, the people who the bill was meant to help, are the people who are indeed using it, with the majority of the users being enrolled in hospice 90%. The majority of participants were ages 65-74, 30%, died at home, 93%, and cited their terminal illness as cancer, 77%. The overwhelming majority of these already dying seniors cited their personal reasons for choosing PAS as an end of life option as loss of autonomy and the inability to do things they once loved. These deaths with dignity acts are being used and will be used by terminally ill patients in other states as an end of life

option to end their suffering. Knowing the opinions of age groups, ethnicities, genders, religions practitioners and those of different marital statuses help to inform law makers of the general consensus among their constituents. State representatives and law makers must know their constituency has an interest in PAS before they attempt to make any sort of referendum to the legislative process. There would be no point in putting a bill or ballot into measure when the state's population is already firmly against PAS. As there are currently six states and D.C. who allow PAS to be be practiced within their borders and more debating the morality of it, we must continue adding to the research that has or has not been analyzed. This study does not just benefit the academic world through a previously unlooked at area but the medical field as doctors in PAS states choose to participate, public policy, healthcare via quality of life and end of life care families who have elders and elders who are looking at end of life decisions.

As this exploratory study's main objective was to look at the interaction of age with difference sociodemographic variables, it fascinating to see that age did indeed have an effect when combined with religion on the opinions of PAS. This indicates there is a need to look further into the interaction effects of age on variables regarding PAS. From this study and previous ones, we can see there is an affect at the bivariate level with race, religion, and marital status; now we must look further into what, how or why our opinions are changing as we age.

This study did have several weaknesses that decreased its generalizability to the general population of the United States. First as this study was focused on the changing opinions of elders', the survey used to gather the data was not focused on gathering information from elders. The survey was also predisposed to gather a younger crowd by

having the interviewer ask to speak to the youngest male of 18 years of age, followed by the youngest female of 18 should the male be unavailable. As the interviewer only interviewed one person from each household, this severely decreased the age pool for elder adults. This led to a small sample of 168 people 66 years of age and older out of the 1,500 people originally interviewed. The interviews were also conducted to those inside the continental United States who had a landline present in their home. This excluded both Alaska and Hawaii from being included in the survey. While only calling via landlines limited the overlap of multiple respondents from the same household being interviewed, it also left out a segment of the population who use cell phones as their home-phone or households who had no means of telecommunication. The survey was only conducted in English, which left out first generation immigrants who typically do not communicate well enough in English to have a full English only conversation via phone. Lastly the survey was not focused on PAS but rather right to die laws and end of life issues. Out of the 44+ questions only one was specifically focused on PAS which incidentally was only asked on Form 2 of the survey. This led to the sample size being cut nearly in half. Lastly as chi square tests of independence were used in an effort to find associations between variables, it does not in fact tell us the strength of the relationships found between the variables.

This exploratory study was only meant to test the waters so to speak in order to encourage further research into the area. The study can be improved by gathering a larger sample which has better distributed age ranges. A larger sample could show more age-related significance on PAS. Further research needs to look not only at associations between variables but their relationships as well. A study targeting elders across the

entire nation with a focus on PAS would greatly improve the literature, especially when combined with sociodemographic variables. There is room for further study by taking state-by-state surveys across the entire nation in an effort to look at the opinions of PAS as populations age. It would be exceedingly interesting to see if there is a difference found in the opinions, when related to age, between states who have death with dignity acts versus those without. This could provide important insight into whether elders in non-PAS states would consider using PAS for end of life care. There has not yet been a study breaking down the difference in state populations and their opinions on PAS. As the 2013 Gallup poll showed Americans were just barely in disapproval of PAS, it would be beneficial to investigate which states are in support and what their population looks like.

The findings from these future studies would greatly contribute to the areas of public policy/legislation, end of life decisions and the right to die movement by informing advocacy groups, state senates, state houses, healthcare providers and our government where regions are standing on PAS and most importantly which segments of the population will change their opinions over time. As the opinions of youth have been proven to be different in certain sociodemographic variables it is important for law makers to know the trends of how these age groups will change, and what segment of the population they possess, so that it can be accounted for when making policy.

To give future insight into the direction of PAS on the national level, this paper predicts that some of the next states to pass PAS legislation will be Maine, Minnesota and New York. All three have been in the Right to Die debate for some time and have once again submitted bills/acts to legislation for this session. As we know from this study and

previously collected statistics, the majority of people who agree with or are using PAS are white, males, have a bachelor's degree or higher in education, and are at least 65 years of age. When looking at population demographics, Oregon's population consists of 16.4% of elders 65+, 87.6% are Whites, 50.5% are females and 30.8% have at least a bachelor's degree in higher education (Census.gov). Washington shows much of the same in their population with 14.4% being 65+yrs, 80.3 are White, 50% are female and 32.9% have at least a bachelor's degree (Census.gov). A recent poll shows that 73% of Maine's voters support PAS. Maine fits closely with Oregon and Washington's demographics with their population consisting of 18.8% of elders 65+, 94.9% being White, 51% are female and 29% have a higher education (Census.gov). A 2016 poll by the Greenburg Quinlan Rosner Research, showed 73% of the states' voters were in support of PAS. The state's population consists of an elder population of 14.7%, 85.4% are White, 50.3% are females and 33.7% have a higher education (Census.gov). New York has tried to pass PAS laws since 1995, with it coming close to succeeding in 2016 when it was passed 14-11 by the New York health committee (DeathwithDignity.org). New York's demographic is promising with their population being comprised of 15% elders (65+yrs, 70% are White, 51.4% are female and 34.2% have a higher education (Census.gov). In addition, as this year a new seat is open on the U.S. Supreme Court panel, PAS is once again in the national spotlight, with nominee Judge Neil Gorsuch. As Judge Neil Gorsuch will be the next Supreme Court Justice, he could hold the swing vote when the right to die debate the U.S. Supreme Court occurs once again. Judge Gorsuch is a known opponent of the assisted suicide and PAS as he believes human life is invaluable and that one should seek to protect it, not destroy it. In his book, *The Future of Assisted*

Suicide and Euthanasia, he compares assisted suicide, in which he includes PAS, with homicide and claims that should be called consensual homicide, as that is what he claims it is. He makes a striking argument stating that as we have constructed so many laws, in the effort to protect life, it goes against what we have created by allowing new laws to destroy it. He goes on to close out his arguments against AS/PAS stating that as this is a topic of legal and moral issues, we can be sure that the debate is not yet over and has actually just begun in the Courts and across the nation.

REFERENCES

American Foundation for Suicide Prevention. (2014). Suicide Statistics. Retrieved from http://afsp.org/about-suicide/suicide-statistics/

Back, A. L., Wallace, J. I., Starks, H. E., & Pearlman, R. A. (1996). Physician-assisted suicide and euthanasia in Washington State: patient requests and physician responses. *Jama*, *275*(12), 919-925.

Denny's. (2015). 55+. Retrieved from https://www.dennys.com/food/55-plus/

Center for Disease Control and Prevention. (2015). 10 Leading Causes of Death by Age Group, United States – 2013. Retrieved from http://www.cdc.gov/injury/wisqars/pdf/leading_causes_of_death_by_age_group_2013-a.pdf

Center for Disease Control and Prevention. (2015). Leading Causes of Death Reports, National and Regional, 1999-2015. Retrieved from https://webappa.cdc.gov/sasweb/ncipc/leadcaus10_us.html

Chin, A. E., Hedberg, K., Higginson, G. K., & Fleming, D. W. (1999). Legalized physician-assisted suicide in Oregon—the first year's experience. *New England Journal of Medicine*, *340*(7), 577-583.

Death with Dignity. (2017). FAQs. Retrieved from https://www.deathwithdignity.org/faqs/

Death with Dignity. (2017). Chronology of Assisted Dying. Retrieved from https://www.deathwithdignity.org/assisted-dying-chronology/.

Death with Dignity. (2017). New York. Retrieved from https://www.deathwithdignity.org/states/new-york/.

Economics and Statistics Administration, U.S. Department of Commerce. (1995). Sixty-Five Plus in the United States. Retrieved from https://www.census.gov/population/socdemo/statbriefs/agebrief.html

Emanuel, E. J., Fairclough, D. L., & Emanuel, L. L. (2000). Attitudes and desires related to euthanasia and physician-assisted suicide among terminally ill patients and their caregivers. *Journal of American Medical Association, 284*(19), 2460-2468.

Freedman, D., Pisani, R., & Purves, R. (2011). *Statistics* (4th ed.). Viva Books.

Get Palliative Care. (2017). Cancer and Palliative Care. Retrieved from https://getpalliativecare.org/whatis/disease-types/cancer-palliative-care/.

Gorsuch, N. M. (2009). *The future of assisted suicide and euthanasia*. Princeton University Press.

Hedberg, K., Hopkins, D., & Kohn, M. (2003). Five years of legal physician-assisted suicide in Oregon. *New England Journal of Medicine, 348*(10), 961-964.

Hopp, F. P. (2000). Preferences for Surrogate Decision Makers, Informal Communication, and Advance Directives Among Community-Dwelling Elders Results from a National Study. *The Gerontologist, 40*(4), 449-457.

Human Resources Code. (n.d.). Retrieved from http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.48.htm

Humphry, D. (2004). *The Good Euthanasia Guide: Where, What, and Who in Choices in Dying*. ERGO Bookstore.

Humphry, D. (2008). *The Good Euthanasia Guide: Where, What, and Who in Choices in Dying*, 4th Edition. Norris Lane Press.

IHOP. (2015) 55+. Retrieved from http://www.ihop.com/menus/main-menu/55-plus

Jacobzone, S., & Oxley, H. (2001). Healthcare expenditure: a future in question. (Ageing populations). *OECD Observer*, 15-18.

Lee, M. A., Nelson, H. D., Tilden, V. P., Ganzini, L., Schmidt, T. A., & Tolle, S. W. (1996).

Legalizing assisted suicide—views of physicians in Oregon. *New England Journal of Medicine*, *334*(5), 310-315.

Lewin T. (1990, December 27). Nancy Cruzan Dies, Outlived by a Debate Over the Right To Die. *The New York Times*. Retrieved From http://www.nytimes.com/1990/12/27/us/nancy-cruzan-dies-outlived-by-a-debate-over-the-right-to-die.html

Manning, M. (1998). *Euthanasia and Physician-assisted Suicide: Killing Or Caring?*. Paulist Press.

Masci David. (2013). To End Our Days. The Social and Political Dimensions of the End-of-Life Debate. Retrieved from http://www.pewforum.org/2013/11/21/to-end-our-days/

McCarthy, E. P., Pencina, M. J., Kelly-Hayes, M., Evans, J. C., Oberacker, E. J., D'Agostino, R. B., ... & Murabito, J. M. (2008). Advance care planning and health care preferences of community-dwelling elders: the Framingham Heart Study. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, *63*(9), 951-959.

McFadden R.D. (1985, June 12). Karen Ann Quinlan, 31, dies; focus of '76 right to die case. *The New York Times*. Retrieved from

http://www.nytimes.com/1985/06/12/nyregion/karen-ann-quinlan-31-dies-focus-of-76-right-to-die-case.html?pagewanted=all

National Hospice and Palliative Care Organization. (2015). NHPCO's Facts & Figures: Hospice Care in America. Retrieved from https://www.nhpco.org/sites/default/files/public/Statistics_Research/2015_Facts_Figures.pdf.

Pew Research Center. (2009). End-of-Life Decisions: How Americans Cope. Retrieved From http://www.pewsocialtrends.org/2009/08/20/end-of-life-decisions-how-americans-cope/.

Pew Research Center. (2009). Growing Old in America: Expectations vs. Reality. Retrieved from http://www.pewsocialtrends.org/2009/06/29/growing-old-in-america-expectations-vs-reality/.

Pew Research Center. (2015). 2005 Right to Die Data Set. [file and data code book] Retrieved from http://www.people-press.org/category/datasets/?download=20018498.

Pew Research Center. (2006). Strong Public Support for Right to Die: More Americans Discussing - and Planning - End-of-Life Treatment. Retrieved from http://www.people-press.org/2006/01/05/strong-public-support-for-right-to-die/2/.

Pew Research Center. (2006). Supreme Court's Decision in Gonzales v. Oregon: High Court Rejects Federal Regulation of Physician-Assisted Suicide. Retrieved from http://www.pewforum.org/2006/02/01/supreme-courts-decision-in-gonzales-v-oregon-high-court-rejects-federal-regulation-of-physician-assisted-suicide/.

Pew Research Center. (2013). Views on End-of-Life Medical Treatments: Growing Minority of Americans Say Doctors Should Do Everything Possible to Keep Patients Alive Retrieved from http://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/.

Pew Research Center. (2010). What do you mean by "continental U.S."? Retrieved from http://www.pewresearch.org/2010/09/27/what-do-you-mean-by-continental-u-s/.

ProCon.org. (2015). State-by-State Guide to Physician-Assisted Suicide. Retrieved from http://euthanasia.procon.org/view.resource.php?resourceID=000132.

Public Health Division & Center for Health Statistics. (2017, February 10). Oregon Death with Dignity Act. Retrieved from http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year19.pdf.

Quadagno, J. (2014). Aging in the life Course; An Introduction to Social Gerontology, 6TH Edition. New York, NY: McGraw-Hill Companies, Inc.

Seale, C. (2009). Legalisation of euthanasia or physician-assisted suicide: survey of doctors' attitudes. *Palliative Medicine*, *23*(3), 205-212.

Social Security Administration. (n.d).Full Retirement Age: If You Were Born In 1960 Or Later. Retrieved from https://www.ssa.gov/planners/retire/1960.html.

Suarez-Almazor, M. E., Newman, C., Hanson, J., & Bruera, E. (2002). Attitudes of terminally ill cancer patients about euthanasia and assisted suicide: predominance of psychosocial determinants and beliefs over symptom distress and subsequent survival. *Journal of Clinical Oncology*, *20*(8), 2134-2141.

Sullivan, A. D., Hedberg, K., & Fleming, D. W. (2000). Legalized physician-assisted suicide in Oregon—the second year. *New England Journal of Medicine*, *342*(8), 598-604.

United States Census Bureau. ((2017). QuickFacts: Maine. Retrieved from https://www.census.gov/quickfacts/table/PST045216/23.

United States Census Bureau. ((2017). QuickFacts: Minnesota. Retrieved from https://www.census.gov/quickfacts/table/PST045216/27.

United States Census Bureau. ((2017). QuickFacts: New York. Retrieved from https://www.census.gov/quickfacts/table/PST045216/36.

United States Census Bureau. ((2017). QuickFacts: Oregon. Retrieved from https://www.census.gov/quickfacts/table/PST045216/41.

United States Census Bureau. ((2017). QuickFacts: Washinton. Retrieved from https://www.census.gov/quickfacts/table/PST045216/53.

Ward, B. J., & Tate, P. A. (1994). Attitudes among NHS doctors to requests for euthanasia. *British Medical Journal*, *308*(6940), 1332-1334.

Washington State Department of Health. (2015). Washington State Department of Health 2015 Death with Dignity Act Report. Retrieved from http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2015.pdf.

Wilson, K. G., Scott, J. F., Graham, I. D., Kozak, J. F., Chater, S., Viola, R. A., ... & Curran, D. (2000). Attitudes of terminally ill patients toward euthanasia and physician-assisted suicide. *Archives of Internal Medicine*, *160*(16), 2454-2460.

VITA

Adrianna Medina

Education

Master of Arts student in Criminal Justice and Criminology at Sam Houston State University, August 2013 – present. Thesis Title: "Elders' Opinions of Physician Assisted Suicide: Factors the make a Difference".

Bachelor of Science (May 2013) in Criminal Justice, Sam Houston State University, Huntsville Texas. Cum Laude.

Academic Employment

Graduate Teaching and Research Assistant to Dr. Travis Franklin in the department of Criminal Justice at Sam Houston State University, August 2013- May 2014. Responsibilities included: Creating and editing data tables. Graded and entered student exam scores using Excel.

Graduate Teaching and Research Assistant to Dr. Melinda Tasca in the department of Criminal Justice at Sam Houston State University, August 2014 – December 2014. Responsibilities included: Prepared lecture slides and notes. Analyzed and designed quiz/exam questions. Researched and gathered material for papers going to publication. Facilitated interaction between students and Dr. Tasca.

Graduate Teaching and Research Assistant to Dr. Britney Hayes in the department of Criminal Justice at Sam Houston State University, August 2014 – May 2015. Responsibilities included: Created, edited and graded exams/quizzes. Revised papers for publication. Researched material for ongoing papers for publication. Managed and taught class lectures in absence of professor. Analyzed and graded students' written essays.

Academic Awards

Graduated Sam Houston State Cum Laude May 2013 with a Bachelor's of science in Criminal Justice.

The Dean's List, Department of Criminal Justice, Sam Houston State University, 2009-2013.