Perceptions and Opinions around End-of-Life Decision-Making

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Submitted to faculty in the Sociology and Anthropology Department
University of La Verne
In partial fulfillment of the requirements for the degree of
BACHELOR OF SCIENCE IN ANTHROPOLOGY
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May 2014
ABSTRACT

End-of-life decision-making in relation to withdrawing treatment or voluntary active death, such as physician-assisted suicide (PAS) and euthanasia, is a complicated matter that is perplexed by both legal and moral concerns. This study proposes that there exists bias in perceptions and attitudes toward minors as autonomous patients in related circumstances. Objectives were to make a comparison between support of withdrawing treatment and voluntary death, as well as to determine perspectives of PAS and euthanasia. 100 participants were collected by non-random convenience sampling at a university in Southern California. The data indicates that individuals are less likely to support patient autonomy and withdrawing treatment when the patient is a minor. However, female support of adolescent autonomy is greater than male support. Additionally, most participants support a parent’s right to make decisions for an infant, though many believed a physician should have greater authority. Finally, knowledge of PAS is not correlated with support of this process; and most individuals are not knowledgeable of PAS or euthanasia. Results reaffirm that there is hesitance to support processes which may have a harmful impact on patients, especially minors, and suggest that individuals perceive minors as more resilient to disease and incompetent to make impactful decisions.
It is the ubiquitous conviction that medicine and its practitioners are miraculous workers who preserve, enhance, and save lives. During times in which we must struggle with disease, physicians are there to guide us, helping us to return to full health. It is precisely this reason for which there lies an existence of tremendous opposition, legal and moral, to the premature death of a patient. Even with such great resistance, however, physician-assisted suicide (PAS) and euthanasia are processes which are currently under debate amongst both physicians and the public. Furthermore, these processes open debate on patient autonomy. Primarily, whether a terminally ill individual has the right to choose a premature death, and moreover, a right which includes physician involvement. Even more controversial is the consideration of whether PAS and euthanasia should ever be implemented in a scenario in which the terminally ill is a minor. Yet, adolescents, children, and infants make up a considerable fraction of this patient population. These are individuals who must engage in a daily struggle with their illnesses, those which have no bias towards the “young and healthy.”

Americans lack an accepting view towards death. With the recent increases in terminal diseases, for instance cancer, the reaction is often to rally together with the primary goal of eradicating the entire existence of the illness—namely, to find a cure. This attitude towards death and illness is often portrayed by the simple usage of words which reflect combative measures. They may call it the “battle against cancer” or claim that “the fight is on” against some other debilitating condition. The concern to spread awareness of how to best effectively manage the process of such conditions, or of providing education on end-of-life care appears less prevalently and less profoundly.

The perspectives that physicians and the public hold on euthanasia and physician-assisted suicide (PAS) are reflective of this attitude towards death. Many physicians state that they
would not participate in the death of a patient who requested it. Members of the general public have similar feelings and would not want doctors to have this right, though the majority of participants in some studies support euthanasia and PAS (Emanuel 2002). Nevertheless, studies have also shown that situational factors, such as a patient’s age, can have an effect on attitudes toward euthanasia (MacDonald 1998).

Law is an impactful variable which shapes these beliefs. Perspectives of physicians and the public are important, as they provide some indication as to whether euthanasia and physician-assisted suicide are issues which should not only be acknowledged through law, but returned to and altered. While a significant increase in support of euthanasia and PAS occurred in the 1970s, it has remained relatively constant since then (Emanuel 2002). In 1997 the Supreme Court ruled that no constitutional basis existed on which to make a ruling on the matters of euthanasia and PAS, and that these issues should be turned to each individual state. Some state legislatures have defeated bills to legalize euthanasia or physician-assisted suicide; other attempts have been refused by voters. Still, four states have now legalized PAS.

While PAS legalization may seem a defeat by some and a win by others, there are strict eligibility requirements and regulations tied to the process of PAS. Among these requirements is that the patient who will be receiving PAS must be at least eighteen years old. Thus, this requirement excludes a portion of the terminally ill population. The United States has seen an increase in children with life-limiting illness and an estimated 50,000 resulting annual deaths (Varela et al. 2012). Yet, these young individuals would not be able to make a decision for themselves nor have one legally made on their behalf to end their life. In addition to legal issues and previously stated concerns over death is a notion that children are nearly immune to serious health conditions, especially those which would likely lead to death. However, it remains that
this is not the case. It remains that to live with a terminal-illness is to be near death, regardless of age.

A LEGAL STANDPOINT

The concept of *active* euthanasia is implied in this research when euthanasia is referenced. The term is defined as a class of euthanasia that consists of death as a direct result of, and actively caused by another individual (Sklansky 2001). An example would be a physician administering a lethal injection into the patient’s body. A significant difference between this form of euthanasia and physician-assisted suicide (PAS) is that PAS does not involve another individual who directly acts to cause death. Rather, PAS usually consists of a physician writing a lethal prescription for a patient who will administer the drug independently (MacDonald 1998).

While individuals’ perceptions on euthanasia and physician-assisted suicide (PAS) may be influenced by a variety of cultural factors, the law also serves as a form of ideology and actual constraint (Bülow et al. 2008; Cohen et al. 2012). Physicians may be liable for harm which comes to the patient, and must abide by an oath and four basic principles of medical ethics, including non-maleficence, or to do no harm. Thus, 39 states as of 2008 explicitly banned assisted suicide by statute (Kopp 2008), and most states apply felony homicide charges for involvement in the suicide of another individual. Therefore, while personal bias does exist and impact health care, the law is typically the final enabler to determine which acts will be taken.
**Legalization for PAS**

In 1994 Oregon’s voters had approved a measure to decriminalize physician-assisted suicide (PAS). The Supreme Court ruled in 1997 that there is no constitutional basis for either legalizing or criminalizing PAS and euthanasia. Thus, the decision was left to the states. Oregon became the first state to legalize PAS, also in 1997. Since then, Washington, Vermont, and Montana have followed, legalizing PAS but not euthanasia.

All four states have adopted strict regulations for PAS. Rules enforced by the state of Oregon are those such as which concern the patient who must be 1) at least eighteen years of age, 2) a resident of the state in which PAS will take place, 3) diagnosed with a terminal illness, and 4) competent to make health-related decisions on one’s own behalf (Sclar 2006). In addition to Oregon’s Death with Dignity Act, other legislative proposals indicate that PAS or euthanasia should be confined to adults only. Additionally, a physician other than the patient’s primary must be consulted and agree on the patient’s prognosis. If PAS is approved, no physician is permitted to witness this act.

Sclar (2006) suggests that these safeguards are in place to protect the physician, while a similar suggestion is that the Death with Dignity Act was framed more with the purpose of aligning with physician preference than what seems to be culturally acceptable by society (MacDonald 1998). Still, others who consider the patient have formed the “slippery slope” argument that suggests the use of euthanasia or PAS in acceptable conditions could in fact lead to abuse of these processes (Sklansky 2001). These legal and ethical concerns exist towards both patient and physician, as both are placed in vulnerable states under these circumstances.
Withdrawing Treatment

While euthanasia may be punishable by law and physician-assisted suicide challenged, withdrawing treatment is condoned through common medical practice in North America (Sklansky 2001). It is legal in the United States under the right to refuse treatment principle (Luce and Alpers 2000), and the American Medical Association (AMA) states that it is not unethical to withdraw treatment if the decision to do so has been made by the patient or appropriate surrogate (American Medical Association 1996). The AMA also approves of some cases to withdraw support of a neonate (Sklansky 2001). In fact, various studies find that physicians may exercise within policy and ethics to hasten the death of a terminal or critical patient in a way that is both legal and ethical, or somewhat ambiguous (Cherniack 2002; Meier et al. 1998, Sklansky 2001). For example, Meier et al. (2008) found that 30 percent of physician participants in a national survey had reduced life-prolonging therapy after the patient had sought assistance in dying.

Advance Directives

Still, while it appears that withdrawing or withholding treatment is more prevalent and discussed, there are instances of hesitation or discomfort when discussing or proceeding with advance directives. For instance, a survey of physicians found that they often felt uncomfortable discussing do-not-resuscitate orders (DNRs) with patients (Cherniack 2002). In a study of African American participants, it was also found that none of the participants had heard about advance directives or living wills from professionals in the health care field (Waters 2001). Additionally, it seems that an age bias exists with DNR orders. Though many elderly in the United States desire to be resuscitated, DNR orders are applied far more commonly to elderly
patients than with child patients, despite what the prognosis of these older individuals might be (Cherniack 2002). Hence, it is curious that withdrawing treatment appears to be prevalent in certain situations, including those in which patients may not be properly informed about advance directives. In turn, is the enquiry of patient autonomy and the roles within the physician-patient relationship.

MODELS OF THE PHYSICIAN-PATIENT RELATIONSHIP AND PATIENT AUTONOMY

Patient autonomy emerged as a major concept in patient care around the 1980s. Until this time, “paternalism” in patient care had been dominant (Charles et al.1999). The model of paternalism in patient care relied on the assumption that physicians know best when concerning the type of treatment that patients should receive. The term, of course, refers to the concept of the paternal instinct, which parents typically demonstrate to protect and guide their children who are seemingly not wise and mature enough to make their own decisions. Patient treatment was therefore a result of a physician’s own careful decision-making or that which was accomplished from deliberation with other physicians.

In contrast to the paternalistic model is the newer “independent choice model” (Quill and Brody 1996). This model provides that the physician is only responsible for objectively stating potential medical care options for a patient’s given situation, and that the physician not give any professional or personal advice. Thus, a physician’s intense specific medical treatment becomes less relevant to the decision-making process. Rather, the patient receives greater authority in this model.
A third approach to patient care is “enhanced autonomy” (Quill and Brody 1996). This model is in strong support of dialogue and collaboration between patient and physician. In this approach, physicians implement their expertise in treatment suggestions, while providing the patient with all other potential options as well. The physician makes a conscious decision to understand the patient’s values and concerns, while the patient should make an understanding of the objective and subjective statements of the physician. A decision will be made after such a discussion, whether it is that preferred by the physician or patient, or both. A look into the perspectives of physicians, health care providers, and the public may reflect the law’s bias in favor of physician-assisted suicide (PAS) and especially of withdrawing treatment, as well as towards legal adults in deciding these matters for themselves.

The question of the legality of child euthanasia or PAS, therefore, has not only to do with state policies, but of how patient autonomy is practiced in the clinical setting. Moreover, it is how implementation is regulated when the patient is a child or infant that is significant. Therefore, in order to understand the complete image of child (minor) decision-making rights in the health care system, an understanding of patient rights laws as it relates to patient autonomy should be noted.

**PERSPECTIVES**

*Physician Views on Euthanasia and PAS*

The law is an influential factor in physician perspectives of euthanasia and physician-assisted suicide (PAS). For example, a 1995 national survey of physicians found that although only 11 percent of participants were willing to provide a lethal prescription when requested by a competent patient, a greater 36 percent would honor the request if it were legal to do so (Meier et
Moreover, some physicians are likely to support requests for PAS or euthanasia if legal, even if they would not want to be a direct part of the process. For instance, Bachman et al. (1996) discovered that Michigan physicians who would not want to participate in PAS or euthanasia are somewhat likely to refer patients for these processes. Overall, however, physicians tend to differentiate between euthanasia and PAS, being more in support of the latter (Emanuel 2002).

**Physician Experiences with Euthanasia and PAS**

Of the same 1995 sample of physicians, 18 percent (320 individuals) had received requests for a lethal prescription, while 11 percent received requests for a lethal injection (Meier et al. 1998). 3 percent reported writing a lethal prescription, while nearly 5 percent indicated that a lethal injection was administered. Of the total who received requests for either PAS or euthanasia, 30 percent responded by being less aggressive with therapy/treatment. Still, Emanuel (2002) reports that it is difficult to indicate the frequency of requests made to physicians due to significant variation between studies. It is also noted that physicians are more likely to acknowledge involvement with PAS or euthanasia when surveys are administered by colleagues or investigators of the same state. Thus, it is feasible that actual occurrence of these processes is more frequent.

**Public Perspectives**

About one-third of Americans support euthanasia and PAS regardless of the circumstance (Emanuel 2002). Roughly the same percentage is supportive when the patient feels that he or she may become a burden to family, or when life becomes meaningless. Of all surveys reported,
the highest frequency of support for either euthanasia or PAS is at 65 percent. Most support is applied only when the patient is in a great deal of pain, although pain itself does not seem to play a significant role in patient requests. It has also been discovered that certain cultural and demographic factors may influence public opinion. Some studies have found that support for PAS decreases as age increases (Kopp 2008). The elderly and African Americans are significantly more opposed to both processes (Emanuel 2002). Likewise, there is good support that females tend to have more reservations about euthanasia and PAS as well. In contrast to physician views, the public does not seem to favor either PAS or euthanasia more than the other. However, a distinction is reported between these processes and withdrawing treatment, which received a greater 90 percent approval. Furthermore, there appears to be a negative correlation between knowledge and support of PAS (Kopp 2008). Finally, it has been suggested that age is a factor which influences attitudes toward euthanasia, where there is positive correlation between age and support (MacDonald 1998).

DECISION-MAKING IN MINORS

While studies aimed at gaining physician and public perspectives on euthanasia and physician-assisted suicide (PAS) have neglected to factor in children or minors in general, a legal perspective might provide insight into what these perspectives might be. In considering the laws in place that restrict the rights of minors and their ability to make medically-related decisions, it may be that euthanasia and PAS applied to minors would receive less support. For instance, multiple PAS regulations are aimed at reassuring that the patient is competent and not coerced to make a decision (Sclar 2006). Moreover, there is concern over minors who are not adolescents, for they are not capable of comprehending such choices.
Decisions Made for Neonates

Decisions to withdraw treatment for terminally ill newborns is commonly a mutual agreement among both physician and parents (Sklansky 2001). Still, both parties may be unintentionally biased in some respects. Parents may be overly stressed or troubled by social and financial pressures, while physicians may inadvertently become partial to non-treatment because treatment is atypical for most newborns are healthy. However, it is an assumption that physicians have the greatest potential to be objective under these circumstances. Still, with respect to the law in regards to euthanasia and the homicide charges which may apply to this practice, it is conceivable that criminal charges could be filed against parents and physician alike. For instance, although the Child Abuse Amendments of 1984 describes a population of infants for whom withholding life-support treatment is not considered neglect, states may still consider it criminal to not treat a patient when it is a responsibility to do.

Minors’ Rights for Legal Decision-Making

Minors have not reached an age determined by the government to have the rights and responsibilities of a legal adult. Individuals in the United States who under the age of eighteen are not granted the right to make legal decisions such as in relation to contracts of varied types. They also may not make personal decisions related to one’s own body such as in the case of piercing or tattooing, which may seem trivial in comparison to medical treatment decisions. In the more serious case of abortion, however, consent it typically required the minor’s guardians as a result of the ruling in Planned Parenthood v. Casey (Rosato 2000). Nevertheless, there do exist cases in which minors are allowed to long-lasting or otherwise considered serious decisions. For example, there are circumstances and states in which a minor can independently obtain
contraceptives. The Federal Drug Administration (FDA) recently approved the use of Plan B, an emergency contraceptive that is used for the purpose of preventing pregnancy if taken within a few days after having sex, without a prescription, by any female of reproductive maturity (FDA 2013).

Despite some exceptions to minors making legal or medical decisions, age does still appear to be a strong determinant in each scenario. In fact, the United States has recognized a “mature minor” principle in ethics that would not work for children or infants, but may be applicable to adolescents. In support of this fact is a psychological perspective which suggests that individuals at the age of 14 have the capacity for decision-making (Sanci et al. 2004). However, a tendency has been found in even young children to understand the irreversibility concept of death (Orbach et al. 1986). Despite these views, infants and children may also experience illness and coinciding features that are those which influence individuals’ perspectives to be in favor of euthanasia, PAS, and withdrawing treatment. Furthermore, views on PAS and euthanasia may promote hesitation to provide minor patients with autonomy. For instance, competence it most commonly an issue only when the patient makes a decision antagonistic to what is regarded as his or her best interest (Buchanan 2004).

END-OF-LIFE CARE OPTIONS FOR MINORS

As recently as 2001, no hospices existed for children in the United States. In contrast, countries such as Romania and Canada already had at least one organization in place, while England possessed twenty (Boyle 2001). While “normal” hospice organizations sometimes provide care to infants and children, staff members may not be adequately trained to deal with patients in these age groups (Varela 2012). Moreover, in a study surveying hospice
organizations in North Carolina, one of the most significant perceived barriers to child hospice care was the lack of referrals from physicians. Physicians whose perspectives were questioned indicated that even while practicing in oncology departments, they often felt unprepared for and uncomfortable with facilitating in-depth end-of-life care (Varela 2012). This is perhaps interesting since reports indicate that oncology physicians more often receive and oblige with requests for euthanasia and physician-assisted suicide (PAS) (Emanuel 2002). In support of this finding are the results of a study by the American Society of Clinical Oncology which indicate that there have been instances of pediatric euthanasia or PAS by oncologists (Emanuel et al. 2000).

**Hospice versus Palliative Care**

Hospice and palliative care are the two primary forms of end-of-life care for patients suffering from a chronic or pro-longed illness. Though the two do not differ in many characteristics, they differ significantly. Hospice care is largely organized around the patient by providing individualized care through in-home services, while palliative care tends to be performed at hospitals, other health care facilities, or even nursing homes. The two also differ in that hospice care requires a physician’s referral and a terminal diagnosis to live only 6 months or less. Palliative care can be received at any point of a diagnosis, whether or not it is terminal. Lastly, curative therapy is forgone in hospice care (Varela et al. 2012). Hence, it may be likely that chronically and, or terminally ill patients would seek both types of care, with hospice being most suitable for those patients near the end of life.

Hospices have a critical responsibility, in that they are required to care for the patient in more aspects than simply medicine. The roles of hospice include encompassing the social,
spiritual, and psychological needs of patients (Lindley et al. 2009). Because the patient is prioritized, about 80 percent of hospice care is received in-home (Baird and Rosenbaum 2003). Moreover, hospices tend to the patients’ right to a dignified death. Hospice organizations possess the presumption that any patient within their care will likely not live much longer, whereas hospitalization may be a symbol of hope that one’s condition will better or reverse.

Hospice teams consist of health professionals, social workers, and volunteers. A medical director often oversees hospice care, though a patient’s own physician may continue in an active role alongside other hospice members (Baird and Rosenbaum 2003). When hospice team members arrive at a patient’s home, there are a number of actions which they can take to provide patient comfort. If medical treatment is needed, it will be provided. Certain medical technology can even be implemented in the home if necessary. Moreover, members of the hospice staff provide support for the patients’ families. During the final stages of a patient’s life and after the patient has died, bereavement is available through hospice for the family members left behind.

Hospice may typically be regarded as a service for the elderly, but the relevancy of hospice care is essential to pediatric patients, and even the discussions of euthanasia and physician-assisted suicide (PAS). In one aspect, pediatric hospice care may actually detour considerations of PAS by providing comfort and support to the patient. Still, the presence of hospice care and knowledge of its purposes could lead to a more ubiquitous openness to carry out end-of-life discussions—even as it relates to our youth. For example, in a research study including parents whose children had died as a result of cancer, earlier recognition of fatality as a final outcome was associated with earlier discussions of hospice care (Wolfe et al. 2000). In addition, earlier recognition of a probable fatality by both parents and physician were consistent with better parental ratings of home-care quality, and also earlier establishment of a do-not-
resuscitate (DNR) order. Among other results was a greater likelihood parents and physician to identify the primary goal of cancer therapy as to reduce suffering, as oppose to cure or reverse conditions.

*Progress for Terminally Ill Minors*

Some progress has been made in servicing young patients who possess a terminal illness. The percentage of United States hospice organizations willing to provide children with care increased by 18% from 2005 to 2007, and hospice care for these young age groups have proven to be effective in not only managing pain symptoms, but also in dealing with spirituality and family grief (Lindley et al. 2009). It is unclear whether this rise has come from increased levels of child illness or increased awareness of these types of care. However, physician involvement or that of other health care professionals in organizing end-of-life care for patients can be a critical determinant of whether or not parents accept death as the most likely outcome for their child, and seek end-of-life specific care.

**BEING PRESENTED WITH A CHOICE**

Sklanskly (2001) provides a discussion over the legal and moral considerations and implications that surround the topic of neonatal euthanasia. He considers the physician-patient relationship by indicating that beneficence or non-maleficence is a common feature in this dynamic, with the physician employing the right to decide the best act of treatment, and that technology has much to do with the perhaps false impression of doing “good.” Suggestions to patients that originate from an attempt at respect for patient autonomy may also trigger “false hope” (Frank et al. 1998). An example scenario appears in a documentary which demonstrates a
troublesome pregnancy and premature birth, in which a neonatal physician describes technology as a trap:

“It is a precarious situation in that you sort of unleash the technology and at a certain point sometimes either it works or it doesn’t work, or you sometimes are in a situation where you’re almost trapped by the technology in that you’ve started something and sure you could stop it just like you can stop any treatment that’s not being successful, but just psychologically from the standpoint of the parent and the people taking care of the baby, [it’s] not as easy as it would seem on the surface (A Death of One’s Own 2000).”

Even when the patient is older than an infant but not yet a legal adult, there may be great hesitation in discontinuing treatment or allowing a minor to be granted patient autonomy. For example, in a study performed with first-year medical students in the United Kingdom in which a hypothetical scenario of a 12-year old cancer patient was presented, and the parents did not want the patient to be aware of a terminal diagnosis, these students in large respected the wish of the parents and did not disclose the prognosis to the patient; age was reported as a major barrier to respecting patient autonomy (Goldie et al. 2005). In the third year of studies, however, many students did state that if faced with the direct inquiry from the patient, they would disclose this information. In addition, in a Canadian study containing 77 minor patients with terminal illnesses, only 1 was provided the knowledge that he was dying (McCallum et al. 2000). The patient was an adolescent and older than many individuals included in the study. These results may indicate a trend in the physician health care provider population in decision-making that concerns disclosure of personal health to patients who are near adulthood but remain minors.

A possibility may be that the health care providers do not believe the child will even comprehend the situation. Buchanan (2004) states that the threshold level of capacity required for legal competence has to rise as the consequences become more serious. The question then may become how to define and measure competence as related to this aspect of health care.
Most children would likely be considered competent in relation to their age, though most would be considered too young to make “important” decisions, such as in regards to health care.

While it may seem counterintuitive for death to be a choice, the individuals who choose this fate have in essence had the decision made for them already. The prognosis of a candidate for PAS in the states in which it is legal must have 6 months or less to live. The same requirement is true for those who wish to receive hospice care. The finding that approximately 90 percent of Oregon’s terminal patients who have used the Death with Dignity Act were also enrolled in hospice care programs are supportive of this claim (Campbell and Cox 2012). Furthermore, it is with disregard of opinion that minors have less options for end-of-life care and capability for decision-making in medically-related issues. As a result, this research will focus on addressing the following research questions and hypotheses.

**Primary Research Question**

Is there bias towards minors as compared to adults in attitudes of decision-making and end-of-life situations?

**Secondary Research Questions**

1) Is there bias towards withdrawing treatment as oppose to active forms of death?

2) What knowledge do individuals possess on the processes of PAS and euthanasia?

**Hypotheses**

1) $H_0$: Knowledge of physician-assisted suicide (PAS) and support levels of this process will have no correlation.
H₁: The extent to which one is knowledgeable on PAS will be negatively correlated with support of this process.

2) H₀: Patient age will have no influence on support levels of patient autonomy.
   H₂: Lower support levels of autonomy will be expressed when the patient is a minor.

3) H₀: Patient age will have no influence on support levels of withdrawing treatment that may lead to a patient’s death.
   H₃: A younger patient will receive less support than an older patient for withdrawing treatment that may lead to a patient’s death.

4) H₀: No variation will exist between support for withdrawing treatment and physician-assisted death (that may consist of physician-assisted suicide (PAS) or euthanasia).
   H₄: Support for withdrawing treatment will be greater than for physician-assisted death (that may consist of physician-assisted suicide (PAS) and euthanasia).

**METHODS**

*Concepts and Instruments*

Concepts which were used in this study include: sex, ethnicity, age group, and parental status. Participants were asked to complete a demographics questionnaire that addressed these concepts (see Appendix A). Answers were provided in each category for participants to choose from, with a fill-in “other” option also provided for the questions of gender and ethnicity. Moreover, participants were asked to mark all ethnicities with which they identify.
The primary research tool was a 31-item survey (See Appendix A). The survey contained 30 statement items on a 6-point scale ranging from completely agree to completely disagree. The statements involved multiple factors, such as voluntary death, patient age, patient autonomy, physician decisions, technology, and hospice. As examples: “Only old people should worry about dying,” and “Life support technology should not be used on a patient for more than 6 months.” Additionally, a two-part short answer question was provided to gather information on participant knowledge of physician-assisted suicide and euthanasia.

Lastly, the 5-item, 7-point Satisfaction with Life Scale by Diener et al. (1985) was included to collect participant satisfaction levels on a global scale. Eligible responses ranged from strongly disagree to strongly agree on statements such as, “The conditions of my life are excellent.” Benchmark scores of 21 through 35 are indications of satisfaction with life to varying degrees, while scores of 19 are below are indicative of dissatisfaction; 20 is considered neutral.

**Sample**

100 participants were collected by non-random convenience sampling at a small private university in Southern California. Most participants (68 percent) completed the instruments in a classroom setting, enrolled in courses of either dance, biology, and or the behavioral sciences. The remaining 32 percent were approached and completed the survey at various times and parts of campus. 73 percent of participants were female, while 27 percent were male. Most participants identified at least in part as Latino, though 43 percent identified with some other ethnicity(s) (see Table 1). Only 11 percent of all participants were found to be parents.
Table 1: Demographic Information

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N=100, *N values and percentages in this chart are based on self-identification and therefore exceed the number of participants. **Write-in ethnicities are placed under “Other.”
**Procedure**

Participants were given a brief verbal statement, as well as an extensive written statement about their rights in this study. Such rights included, but were not limited to: 1) the right to withdraw from the study at any time, 2) refuse to answer any question, and 3) to remain anonymous without consequence of any variety. Signed consent forms were collected, and kept separately from the demographic sheet and survey in order to maintain anonymity. Participants were also provided with a copy of the consent form, which was attached at the end of each survey. All surveys were administered in person during the months of March and April 2014.

**Measures**

The main objective of this study was to determine if bias exists around perceptions and opinions of end-of-life decision-making. Although multiple demographic variables were used, gender was the only explicit variable of focus and was applied to hypothesis 5. Statistical tests were applied to respond to hypothesis 1 and 5, and frequencies were evaluated and compared for hypotheses 2-4.

**Hypothesis 1:** Part 1 of the short answer survey responses was implemented in response to hypothesis #1. Knowledge was defined as understanding at least one of the following three concepts related to PAS: 1) the patient’s consent must be provided, 2) death comes by some form of application (e.g. consuming lethal drugs) as oppose to a form of withdrawing treatment, and 3) death must already be imminent. It was required that concept 1 be explicitly stated, though synonyms for “consent” were acceptable (e.g. permission). Concept 2 allowed for a broader range of responses. For instance, lethal injection as a form of application was accepted, although
this process actually refers to euthanasia. The reason for the flexible criteria of concept 2 is due to the understanding that individuals’ support of euthanasia compared to PAS does not greatly differ (Emanuel 2002). However, there is in fact significant variation between support of these processes and withdrawing treatment. Responses were accepted for concept 3 when the concept was explicitly stated in some form, or if the hypothetical patient was referred to as “terminal” or as being in some type of extreme condition. Knowledge was used as a variable against statement 30.

Hypotheses 2-4: Hypothesis #2 was addressed by comparing response frequencies from statements 11 and 19. The same procedure was applied to hypothesis #3 and #4 using responses from statements 5 and 27, and 21 and 30, respectively.

Short-Answer Analysis: Key words/phrases from the short answer responses were transcribed and subsequently translated into codes generated by the researcher. Following this process, frequencies of each code was recorded and analyzed in comparison to existing research, with a focus on variance between PAS and euthanasia codes.

RESULTS

Hypothesis 1 – Correlation between Knowledge and Support of Physician-Assisted Suicide

H₁ indicated that knowledge of PAS would be negatively correlated with support. A Pearson’s chi-squared test was applied to the relationship between knowledge and support of PAS and was not found to be statistically significant, \( X^2 (2, n=100) = .930, p > .05 \).
Hypothesis 2 – Relationship between Support of Patient Autonomy and Patient Age

H$_2$ indicated that lower support for patient autonomy would be expressed for a minor than for a general population of patients. Inclusion of a specified patient age altered support levels for patient decision-making, in which there was less support when the patient referenced was a minor. The mode for statement 11 (“Only the patient should make final decisions about his or her medical treatment”) was response 3, “slightly agree.” 27 percent selected this response. Overall, 76 percent, the majority, agreed with the statement to some extent. The mode for statement 19 (“A 14 year-old who has a terminal medical condition should be allowed to make decisions about his/her treatment”) was response 4, “slightly disagree.” 25 percent selected this response. Overall, only 42 percent agreed with the statement to some extent.

Hypothesis 3 – Relationship between Support for Withdrawing Ineffective Treatment and Patient Age

H$_3$ indicated that support levels for withdrawing treatment in a young patient would be lower than for an adult patient. It was discovered that there was in fact a higher frequency of disagreement for withdrawing ineffective treatment when the patient is young, as opposed to when the patient is an adult. The mode for both statements of comparison was response 4, “slightly disagree.” 23 percent selected this response for statement 5 (“If medical treatment was not making an adult patient better, it would be best to stop it”), while 30 percent did so for statement 27 (“If medical treatment was not making a young patient better, it would be best to stop it”). Overall, 44 percent agreed with statement 5, and 35 percent with statement 27.
Hypothesis 4 – Support for Withdrawing Treatment vs. Active Death Involving Physicians

$H_4$ indicated that support for withdrawing treatment would be greater than support for hypothetical legalized assisted death. Participants had less support for withdrawing life support after 6 months than they did for a legal process of physician-assisted death. The majority of participants (63 percent) disagreed with statement 30 (Even if physicians could legally assist a patient with dying, I would be against it”). The majority (57 percent) also disagreed with statement 21 (“Life support technology should not be used on a patient for more than 6 months”).

Short Answers – Knowledge of Physician-Assisted Suicide and Euthanasia

The responses and frequencies for part 1 of the short answer, which referred to describing any knowledge of PAS are found in Table 2. The frequency of participants who responded was 87 percent. The remaining 13 percent of participants left the field blank or wrote, “I don’t know” in some form. The most common response was that physicians are involved in the process (49 percent). For example, “A physician helps someone who would like to pass on.” The second most frequent response was that it is a voluntary/collaborative process in which the patient makes the decision (33 percent). Among the least frequent responses were that the process is ethical, a form of providing moral support, and is the same thing as euthanasia (1 percent frequency for all). An example statement from a participant was, “I was under the impression that assisted suicide is in fact Euthanasia…”

The responses and frequencies for part 2 of the short answer, which referred to describing any knowledge of euthanasia, can be found in Table 3. The frequency of participants who responded was 79 percent. The remaining 21 percent of participants left the field blank or wrote
“I don’t know” in some form. More individuals left the field blank for euthanasia than for PAS. The most common response for this process was that it involved some type of injection or shot (9 percent). For example, one participant described it as: “It’s when you get injected and you pass away I believe this is what Euthanasia is.” The second most frequent response was that the family or relative(s) of the patient decide for euthanasia to occur (8 percent). Among the least common responses were that euthanasia occurs in old people, is a quick death, is legal, and occurs because the living thing is a burden (1 percent frequency for all). One individual wrote, “Putting down a something alive because nobody wants to take care of it.”

Table 2: PAS codes

<table>
<thead>
<tr>
<th>Reference to PAS</th>
<th># of Appearances</th>
<th>Statement Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician is assisting</td>
<td>49</td>
<td>56</td>
</tr>
<tr>
<td>Voluntary/collaborative</td>
<td>33</td>
<td>38</td>
</tr>
<tr>
<td>Death is forthcoming</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Withdrawing treatment / “pulling the plug”</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Any health provider assisting</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Any individual assisting</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>“Euthanize”/Euthanasia</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Pain as factor</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Comfortable process</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Legal</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Ethical</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>A form of providing moral support</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Would be a burden to physician</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Physician assistant (PA) helping with death</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>


n=87
Table 3: Euthanasia Codes

<table>
<thead>
<tr>
<th>Reference to Euthanasia</th>
<th># of Appearances</th>
<th>Statement Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection/shot</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Family’s decision</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Pulling plug/ off life support</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Humane/ ethical</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>“To sleep”</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Animals</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>A necessary last resort</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Treatment plan</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>“Putting down”</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Pain relief</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Assisted suicide</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Slow process</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Death in mass numbers</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Painless death</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Doctor’s decision</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Assistance can be from non-physician</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Assistance is from physician</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Old people</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Patient is burden</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Quick death</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Easy process</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Legal</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Non-permanent in humans</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Killing</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Helping</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Instant death in animals</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Premature death</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>A drug substance</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

\(n=79\)

**Variation in Support of Patient Autonomy in a 14 Year-Old.** Although it was not part of the hypotheses, a One-Way Analysis of Variance statistical test found that female support for adolescent autonomy was significantly greater than male support. It was found that females had a greater tendency to support statement 19 ("A 14 year-old who has a terminal medical condition..."
should be allowed to make decisions about his/her treatment.”) as oppose to males. The mean for males ($M = 4.23$, $SD = 1.505$) was significantly higher than for females ($M = 3.56$, $SD = 1.352$), $F(1, 96) = 4.485$, $p < .05$.

Table 4: One-way ANOVA for Gender and Support of Patient Autonomy in a 14 Year-Old

<table>
<thead>
<tr>
<th></th>
<th>SS</th>
<th>Df</th>
<th>MS</th>
<th>F</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>8.709</td>
<td>1</td>
<td>8.709</td>
<td>4.485</td>
<td>.037*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>186.393</td>
<td>96</td>
<td>1.942</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>195.102</td>
<td>97</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$n=98$, *$p < .05$

**Decision-Making for Infants.** Additionally, it was discovered that 43 percent of all participants support physician authority to supersede that of the parent in the case of decision-making for an infant patient (discovered by responses to statement 7). However, slightly more than half (56 percent) of participants were in disagreement.

**DISCUSSION**

**Relationship between Knowledge and Support of PAS**

No significance between knowledge and support of PAS was found. These results oppose findings in Emanuel’s (2002) review of opinions on physician-assisted suicide (PAS) and euthanasia in the United States. That is, an increase in knowledge of PAS is correlated with a decrease in support. The result differences in this current study and Emanuel’s review could be due to the criteria implemented in defining PAS knowledge. In this study, three criteria were used and analyzed through short answer responses.
**Patient Autonomy Bias**

The frequency of support for a terminal 14 year-old to make health care decisions did not match that for a general population of patients with no provided age. This is consistent with many issues of law in the United States which restricts minors rights in relation to situations that are deemed harmful and, or long-term in some respect. It is also consistent with Goldie et al.’s (2005) study which found that medical students were greatly hesitant to disclose a 12 year-old’s prognosis to that patient and reported that age as in fact a barrier to respecting patient autonomy.

There was only a 7 percent variation in the mode response (“slightly disagree”) to statements referred to in hypothesis #3. These statements indicated that ineffective treatment should be withdrawn in 1) adult patients and 2) young patients. There was less support in the case of young patients. This may display a connection between findings that patient age influences attitudes toward voluntary euthanasia, where less support is displayed for the participation of children (MacDonald 1998). Since the modes for both statements were the same and occurred at a similar frequency, however, it may also be that some individuals would be against treatment removal regardless of the patient’s specific age or scenario.

**Withdrawing Treatment Bias**

Participants had more support for withdrawing ineffective treatment in an “adult patient” than for a “young patient.” This mentality is consistent with findings in Varela et al. 2012, which demonstrate that families of young patients often seek curative therapy and do not easily transition into accepting less aggressive types of care, even when the prognosis of the patient suggests that curative therapy would be irrelevant or ineffective. Additionally, the study discovered that physicians are also hesitant to accept the patient’s condition due to the age of the
patient. Varela et al’s (2012) findings and the findings of this study suggest that individuals are more hesitant to “give up” on minors than they are adults.

**Withdrawing Treatment vs. Active Death**

It was found that withdrawing treatment received less support than PAS or euthanasia (in the scenario of it being legal). This contradicts findings that individuals tend to have greater support for withdrawing treatment than either of these two latter processes which are active, direct forms of causing death (Emanuel 2002). Furthermore, support for withdrawing treatment may be as frequent as 90 percent, whereas the most support received for either PAS or euthanasia does not typically exceed 65 percent.

**Participant Knowledge of PAS and Euthanasia**

Past studies have demonstrated that the public has about the same support for both PAS and euthanasia (Emanuel 2002). Due to these findings, participants in this study were asked to describe their understandings of these processes. Interestingly, it was found that individuals’ perceptions of PAS and euthanasia were noticeably varied. The short answer responses demonstrate that more participants believe that PAS is a form of withdrawing treatment than they do euthanasia. Additionally, about one third of participants stated that PAS is a voluntary procedure, whereas most individuals who referenced decision-making believed that euthanasia is a decision made by a patient’s family member(s). While these responses do not support results of other studies which indicate that the public perceives PAS and euthanasia similarly, they may demonstrate a connection between knowledge and law. For example, the top three responses for PAS were consistent with some of the main criteria for legalized PAS in states such as Oregon.
In addition, the most frequent response for euthanasia (that it consists of a direct injection/shot) is a major variance between PAS and euthanasia. Also, this difference appears to be a main factor in preventing euthanasia from becoming legal anywhere in the United States.

**Gender and Support Levels of Adolescent Autonomy**

Though there was a significant difference between different genders in relation to support levels for a 14 year-old terminal patient to make decisions about health care, it was males that had less support than females. This is perhaps somewhat surprising since some studies have indicated that females have a greater tendency to oppose PAS and euthanasia, and therefore it may be anticipated that females would more opposed to any form of decision-making which has greater potential to lead to a harmful outcome.

**Decision-Making for Infants**

This study found that most participants (56 percent) believe a parent as oppose to a physician should make decisions related to medical care of an infant. Still, 43 percent felt the opposite. There are benefits to having both parents and physicians possess authority to make a decision on behalf of a neonate (Sklansky 2001). Parents are believed to possess an innate-type of enduring love for their child which would allow them to make decisions which are in the best interest of the child. However, it also suggested that judgment may be clouded when a neonate is born with a medical disability. Physician too, while they having taken an ethical oath, may be subject to bias for what is considered “normal” in a newborn. Additionally, they may consider the cost of treating and even sustaining the life of a child when making suggestions about
treatment options. Regardless, it has been found that at least in the case of euthanasia in neonates, that this decision is a joint one, made by both parents and physician.

LIMITATIONS AND CONSIDERATIONS FOR FURTHER RESEARCH

This study was limited due to sampling, such as small sample size and skewedness in demographics. Additionally, time and lack of resources was a major limiting factor. Future studies should place an emphasis on representative samples of the overall population in the region, as well as on a comparison between an equal population of parents and non-parents. Furthermore, qualitative research will be beneficial to understanding the perspectives and opinions of individuals on end-of-life decision-making, as it was determined by participant responses that a broad range of understandings exist.
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Sclar, David

Sklansky, Mark


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Waters, Catherine M.


Wolfe, Joanne, Neil Klar, Holcombe E. Grier, Janet Duncan, Susanne Salem-Schatz, Ezekiel J. Emanuel, and Jane C. Weeks

APPENDIX A

Consent Documents and Instruments
CONSENT TO PARTICIPATE IN RESEARCH

Early Death in Minors: The Role of Decision-Making

You are being asked to participate in a research study conducted by Angelica Alvarez, a senior thesis student from the Sociology and Anthropology Department at the University of La Verne.

Purpose of the Study
The purpose of this study is to assess what factors may influence University of La Verne students' perceptions of decision-making in children, medical care, and end-of-life situations pertaining to health care.

Procedures
If you decide to participate in this study, you will be asked to read and sign a consent form. Upon receiving your consent, you will be asked to participate by completing a survey that will take approximately 5-10 minutes to complete.

Potential Risks and Discomforts
There is a potential risk that you may find some questions psychologically challenging. Some questions may place you in hypothetical or real past scenarios that could cause discomfort. If necessary, you should seek counseling services, such as at the university’s counseling center (located in Hoover building, 2nd floor). You may skip questions or withdraw from the survey entirely if necessary.

Potential Benefits to Participants and/or Society
There are no direct benefits to participants and/or society for participation in this research.

Payment for Participation
All participants will be given an individual package of candy for completing the survey.

Confidentiality
The survey you complete contains no identifying features. Your answers will not be connected to you, and your participation in the study will remain confidential. Only the researcher and academic contributors to this research study will view any survey materials or analysis of such materials. Otherwise, any information that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

Participation and Withdrawal
You are not obligated to participate in this study. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may refuse to answer any questions and still remain in the study. The investigator may withdraw you from this research if circumstances arise which may warrant doing so.

Identification of Investigators
If you have any questions about this research study or wish to receive the results, you may contact Angelica Alvarez at angelicaalvarez92@yahoo.com.

Rights of Research Participants
You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.
If you have questions regarding your rights as a research participant, contact Jeffrey Gunn at jgunn@laverne.edu, or Marcia L. Godwin, Ph.D., IRB Director, at 909-593-3511, extension 4103, (mgodwin@laverne.edu). University of La Verne, Institutional Review Board, 1950 Third Street, CBPM 123, La Verne, CA 91750.
Dear Participant,

You are being asked to participate in a research study conducted by senior thesis student Angelica Alvarez, from the Sociology/Anthropology Department at the University of La Verne. The purpose of this research is to assess what factors may influence perceptions of decision-making and end-of-life situations in health care.

As participant, you will complete a questionnaire that will take approximately 5-10 minutes to complete. Please be aware that your participation is voluntary, and that there are no right or wrong answers. Your participation will remain confidential, and your responses will not be associated with you. You may withdraw from the survey at any time or refuse to answer any question without consequence. Thank you for your participation!

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of the consent form.

______________________________
Printed Name of Participant

______________________________
Signature of Participant Date
**Demographic Information**

Some background information is necessary to evaluate this research. Please help by answering these questions.

What is your gender?

- [ ] Male
- [ ] Female
- [ ] Other

What is your ethnicity? Please mark all which you identify with.

- [ ] Black
- [ ] Asian
- [ ] Caucasian
- [ ] Latino/a
- [ ] Pacific Islander
- [ ] Other(s)

Please identify your age group:

- [ ] 18-21
- [ ] 22-25
- [ ] 26-29
- [ ] 30-33
- [ ] 34-37
- [ ] 38 or older

Are you a parent?

- [ ] Yes
- [ ] No
For the following statements, please check the box which corresponds to your opinion.

<table>
<thead>
<tr>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Generally, children should be allowed freedom.</td>
</tr>
<tr>
<td>2. Society’s resources should focus more on the young and less on the old.</td>
</tr>
<tr>
<td>3. Only old people should worry about dying.</td>
</tr>
<tr>
<td>4. A child is more likely to overcome a terminal illness than an elderly.</td>
</tr>
<tr>
<td>5. If medical treatment was not making an adult patient better, it would be best to stop it.</td>
</tr>
<tr>
<td>6. Hospice is a place, not a type of health care.</td>
</tr>
<tr>
<td>7. When dealing with the health of infants, physicians should have greater authority to make decisions than the parent(s).</td>
</tr>
<tr>
<td>8. If I were terminally-ill, I would feel that I am being a burden on my family.</td>
</tr>
<tr>
<td>9. Teens are not wise enough to make long-term decisions.</td>
</tr>
<tr>
<td>10. I would be sad, but understanding if someone close to me was ill and wanted a physician to help him/her pass away.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Completely Agree</th>
<th>Mostly Agree</th>
<th>Slightly Agree</th>
<th>Slightly Disagree</th>
<th>Mostly Disagree</th>
<th>Completely Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
<td>(4)</td>
<td>(5)</td>
<td>(6)</td>
</tr>
</tbody>
</table>
11. Only the patient should make final decisions about his or her medical treatment.

12. An elderly individual should have the right to die with the help of a physician.

13. If I was terminally ill, I would like to have the option of having a physician help me die.

14. If I was diagnosed with a severe medical condition, I would want a second opinion.

15. Age should influence how much freedom children are allowed.

16. I might not want to live if I experienced at least moderate pain on a routine basis.

17. Under no circumstance should a physician contribute to the death of a patient.

18. Even if someone has a terminal illness, they should not die “unnaturally.”

19. A 14 year-old who has a terminal medical condition should be allowed to make decisions about his/her treatment.

20. I have experience with death.
21. Life support technology should not be used on a patient for more than 6 months.

22. There is always a chance that someone with a bad medical condition can become healthy.

23. Physicians have the patient’s best interest in mind.

24. A patient’s right to be involved in medical decisions is important.

25. Suicide is wrong.

26. Hospice is only for elderly individuals.

27. If medical treatment was not making a young patient better, it would be best to stop it.

28. It is okay to discontinue the life support of a premature newborn.

29. Someone who is on life support is just as alive as someone who is not.

30. Even if physicians could legally assist a patient with dying, I would be against it.
Below are five statements with which you may agree or disagree. Using the 1-7 scale below, please indicate your agreement with each item by placing the appropriate number next to that item.

1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Neither Agree or Disagree
5 = Slightly Agree
6 = Agree
7 = Strongly Agree

_____ In most ways my life is close to my ideal.
_____ The conditions of my life are excellent.
_____ I am satisfied with life.
_____ So far I have gotten the important things I want in life.
_____ If I could live my life over, I would change almost nothing.

Please briefly describe your understanding of the two concepts below:

1) Physician-Assisted Suicide:

2) Euthanasia: