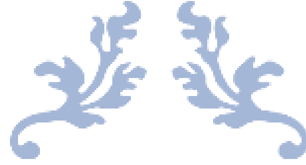

ATTITUDES TOWARDS PHYSICIAN ASSISTED SUICIDE

Madeline Schwahn

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HONORS CAPSTONE PROJECT

University of Wyoming

Introduction

Physician assisted death, or aid-in-dying laws have been passed in eight states throughout the U.S., as well as the District of Columbia. These states include Oregon, Washington, Vermont, California, Colorado, New Jersey, Maine, and Hawai'i (*Death With Dignity* 2019). Physician-assisted death originates from the idea that people with terminal illnesses should have the right to make any end-of-life decisions themselves, instead of those choices being made by the government, politicians, or religious groups. There is a stigma that if these death with dignity laws are passed then people who are capable of still living a long, relatively healthy life will abuse this ability; this is largely not the case (*Death With Dignity* 2019). Death with dignity laws only allow mentally competent adult state residents, with a terminal illness and prognosis of six months or less, to request a prescription medication to accelerate their inevitable death. Two physicians must confirm the patient's residency, diagnosis, prognosis, and competence before the request can be fulfilled (*Death With Dignity* 2019). Allowing adults to make this decision for themselves provides them with a sense of dignity, control, and independence, in an otherwise stressful and depressing time. The right to die is important because it can provide peace of mind to individuals who would otherwise be forced to endure the financial stresses of their end-of-life care, as well as bring stress to family members who could be held responsible for their caregiving.

The question of how demographics impact attitudes towards the utilization of physician assisted suicide will be explored. Research participants will include individuals who are 18 years old or older, and they will be asked to participate in a short confidential survey. The survey will include questions that are aimed at providing information about individual characteristics, such as gender identity, marital status, and perceived socioeconomic status, etc.. Following these

individualized questions, respondents will be asked to rate their level of acceptance in regards to the use of physician assisted suicide. These questions will be constructed through the lens of patient vignettes, where patients will be assigned a terminal illness with a six month prognosis. The demographics of gender and age will vary throughout the patient vignettes. The results of this survey will be expected to present a general idea on the respondents' attitudes towards physician assisted suicide, and the impact of demographic characteristics on these stances.

This research is important because as of now there are no death with dignity laws, or physician-assisted death statutes, in a majority of U.S. states. There may come a time when this type of policy is discussed by local legislators, so it is helpful to understand the attitudes constituents hold on this subject. There is potential for citizens to want laws passed in favor of death with dignity acts because it may impact their loved ones as they continue to age, not to mention their own lives. New Jersey, Maine, and Hawai'i legalized physician assisted suicide in 2019, which shows that support for these laws is continuing to grow, and it will likely become an issue to be seriously discussed by more states (*Death With Dignity* 2019). This research adds a contribution to the discussions and studies on death with dignity laws because it includes a sample of people from all age groups, with a majority of respondents residing in the or around the Wyoming area. This sample consists of both young and old people, with diverse backgrounds. Normally, this topic is focused on the opinion of the older generations, and in locations with more vibrant liberal ideologies. These respondents will have to make these legislative decisions in the future and their opinions on the matter should be taken into account.

Literature Review

DEATH WITH DIGNITY

Death with dignity movements began in the United States with Oregon in 1993. Elven Sinnard, Eli Stutsman, Mark Trinchero, Dr. Peter Goodwin, and Myriam Coppens founded the Oregon Right to Die political action committee, with a goal to create and pass the Oregon Death With Dignity Act. Oregon voters approved the ballot initiative, which would allow those who suffer from terminal illnesses to hasten their death with consultation from their physicians and protected by strict safeguards. With the success of the Oregon Right to Die committee, Oregon became the first U.S. state, and one of the first jurisdictions in the world, to officially legalize medically aided dying (*Death With Dignity* 2019). The official website for the Death With Dignity organization has noted that death with dignity laws can also be referred to as physician-assisted dying (PAD), or aid-in-dying laws. All of this stems from the idea that competent terminally ill people should be able to make their own end-of-life decisions and determine how much suffering they should endure. Maintaining personal autonomy is a priority for the supporters of this movement and organization. Protections within the statute ensure that patients requesting aid-in-dying meet the proper requirements, which according to the Death With Dignity organization includes: confirmation from two physicians of a patient's residency in the state, diagnosis, prognosis of 6 months or less, mental competency and voluntariness (*Death With Dignity* 2019). Strict safeguards such as these protect patients and help physicians determine worthy candidates. The success of the Death With Dignity Act in Oregon, and the hard work of the committee, has led to its acceptance in other states throughout the nation.

The notion of dying with dignity has spread throughout the United States over the years, and it has now been legalized in 8 states, as well as the District of Colombia (*Death With Dignity 2019*). The Death With Dignity website lists all locations where physician-assisted death has been legalized, and it includes California, Colorado, Hawai'i, Maine, New Jersey, Oregon,

Vermont, Washington and D.C. Policy surrounding this subject includes the well-known Proposition 161 in California (Clark and Liebig 1996). This proposition represented the California Death with Dignity Act which was passed in the state. Research has shown that a surveyed elderly population in California was supportive of Proposition 161 being passed, and they valued having the opportunity to maintain independence at the end-of-life stage (Clark and Liebig 1996). The slow spread of acceptance for physician assisted suicide laws throughout the country showcases the potential for legalization in other states. When policies such as this gain attention there are two sides that debate the issue, those who support the legalization of physician-assisted death and those who do not.

The arguments made on behalf of physician-assisted death showcase the benefits to choosing one's time of death when confronted with a terminal illness. When patients are diagnosed with a terminal illness and given a short prognosis many advocates believe that the patient should have the ability to choose how they want to end their life, and the pain they are willing to endure. The issue of pain management and quality of life is crucial to the arguments made for PAD, particularly when patients do not have adequate access to palliative care. Some scholars have deemed it unethical to keep patients who do not have access to high quality palliative care from exercising their right to die (Barutta and Vollman 2015). They describe palliative care as a part of the medical industry that is not equally accessible for all citizens. If palliative care is not a viable option for an ill patient, it is not ethical for the medical field to force them to suffer until they succumb to death (Barutta and Vollman 2015). This argument can be pertinent to citizens in rural states such as Wyoming because individuals may not be located in an environment in which consistent, quality palliative care is available. Another proponent for physician assisted suicide is that it helps patients who feel that their independence has been

stripped from them, due to their illness, maintain personal autonomy. It has been found through studies that maintaining autonomy is extremely important to terminally ill patients (Cassidy 1994). They may have lost their ability to live on their own or function physically without aid, so the ability to make this type of decision gives them back a sense of control over their lives. It is also argued in this study that allowing patients the right to die upholds the notion of placing quality of life above personal political or religious opinions (Cassidy 1994).

Arguments against the legalization of physician-assisted death often focus on how the process could take advantage of vulnerable groups, and that it could place stress or guilt on the physicians that process their patient's requests. Studies have looked at how physician assisted suicide laws could negatively impact vulnerable groups and serve as a "slippery slope" towards the abuse of these practices (Battin et al. 2007). Vulnerable groups include women, the elderly, individuals without insurance or from low socioeconomic status, the less educated, racial or ethnic minorities, and those with psychiatric illnesses (Battin et al. 2007). However, through this study these vulnerable groups were shown to not be negatively impacted by the presence of physician assisted suicide laws (Battin et al. 2007). Many studies have shown the importance placed on demographics and other personal characteristics when considering this form of end-of-life care. Certain groups within society are viewed as needing protection against the harms of the world, so they are used as an argument against controversial medical practices such as this. Despite this study's debunking of PAS negatively effecting vulnerable groups, it is still a prominent argument utilized against these laws. The effects physician assisted death have on the physicians that carry out these requests has been explored as well (Brassfield, Mishra and Buchbinder 2019). It has been found that the conscience plays an important, inseparable, role in medical care due to its ties to the morals and ethics of patient treatment. A physician must

analyze themselves and what sort of care they are comfortable with providing (Brassfield et al. 2019). From the perspective which negatively views PAS, physicians may feel forced to perform physician assisted suicide, despite how it may go against their personal code of ethics. Professionals also warned against "selling" physician-assisted death to ill patients because of the negative effect it would have on family members, depressed patients, and our culture (Hendin 1995). Moving too quickly towards physician assisted suicide could lead to a cultural shift where life is no longer considered as valuable and death is normalized to an extreme extent. It is also considered that family members may not be prepared for the early loss of a loved one, which could cause strain on their relationships and personal mental state.

IMPORTANCE OF DEMOGRAPHICS

The impact that demographics have on the acceptability and legalization of physician-assisted death laws has been examined through previous studies. As defined above through a study, vulnerable groups comprise several aspects of concern within the subject of physician assisted suicide (Battin et al. 2007). Women, the elderly, those with low socioeconomic status, racial or ethnic minorities, and those with psychiatric illnesses are often thought of as groups that need to be protected from harm or abuse. A study similar to this one, that utilized patient vignettes to determine when PAS is acceptable, was conducted; however their study was conducted on a sample group dissimilar to that of this study (Fileux et al. 2003). It has been found that age is an important demographic for positive attitudes towards physician assisted suicide. The older a patient is, the more likely it is that people will be accepting of their decision for accelerated end-of-life treatment. Another study found that physicians were more likely to grant requests from patients who were in severe pain and were not believed to be depressed at the time of request; this showcases the priority of patient comfort over protecting potentially

vulnerable groups. Within the same study, women did not appear to make up a large portion of those making requests, while the elderly did (Meier et al. 2003). This study did not investigate what factors held women back from making more requests, so the origin of motivation, or lack thereof, is unclear.

Certain demographics are held in high regard and protected from harm more than others. Women, the very young, and the elderly are groups that tend to be given more protection through legislature and societal norms. It has been shown that physicians employ careful decision making when considering requests for physician assisted suicide, and demographics do not have a severe impact on their choices (Onwuteaka-Philipsen et al. 2010). Overall, research into the impact patient demographics have on attitudes towards physician assisted suicide have shown that gender is not significant factor throughout this process; age, however, has been known to make an impact because attitudes are more positive towards its use on the elderly. All previous evidence provides valuable information as to why it is crucial to investigate when physician-assisted death is considered to be acceptable, and the impact demographics have on the attitudes towards this subject.

HYPOTHESES

The present study is meant to explore the attitudes towards physician assisted suicide and the barriers that it encounters in regards to patient demographics. While previous studies have been conducted regarding perspectives on PAS in relation to demographics, their research was often limited to a small population, and typically occurred in more urban areas. This research is also limited to a small population, but a majority of respondents are from more rural areas. The interaction of patient demographics and attitudes towards physician assisted suicide were explored through other studies, and it was found that demographics did not affect the outcome of

the request (Fileux et al. 2003). For this study, age and gender will be the two patient demographics used to measure attitudes of physician assisted suicide.

It is expected that respondents will not be as accepting to the use of physician assisted suicide on younger patients, but more accepting towards its use on the elderly. It is also predicted that the gender of the patient will not have a statistically significant impact on the attitudes of respondents. This means the patient being male or female will not alter the participant's opinion on physician assisted suicide. Furthermore, it is considered that the type of illness may have an effect on the attitudes towards PAS, seeing as participants may find some terminal illnesses more severe or painful than others. Because of this, a specific terminal illness will not be given to patients in the patient vignettes.

Data and Methods

Data and Sample

This study will take a hybrid quantitative and qualitative approach to address physician assisted suicide by assessing the attitudes of respondents who are 18 years or older. The survey will relate physician assisted suicide and patient demographics in order to understand the influence of aspects such as age and gender on the subject of PAS. Studies have shown that patients considered to be in vulnerable groups, including women and the elderly, are not at heightened risk for being taken advantage of in regards to PAS, although there is a stigma surrounding the subject that argues otherwise. This will be examined through a short online survey. Participants will be given an outline of the purpose of the survey, be advised of any potential risks or discomforts, and given the opportunity to consent to participate. Following this, participants will be asked to provide personal background information, such as age, gender identity, marital status, religious affiliation, etc. None of the background information will

conflict with the confidentiality of the survey, as none of the information asked for could lead to the identification of any individual. Various patient vignettes will be presented and participants will be asked to give their opinion on if it is acceptable or not for the given patient to receive physician assisted suicide. This will be followed by a comment section which will provide participants with an opportunity to state any additional comments or opinions.

The participants will be obtained as a result of email list-serves, social media, and personal outreach. A flier was created for marketing the survey, and it included information on the subject and purpose of the study, as well as an estimated time of how long the survey would take to complete. My personal contact information was attached to the flyer as well so that any questions from participants could be easily directed. The flyer also contained the requirements for participation in the study, which only consisted of an age requirement. Participants must be a minimum of 18 years old so that their opinions are more impactful for voting on state policies. The flyer was posted on social media using personal accounts, and it was also distributed through email on list-serves. My current professors were reached out to as well, and many of them agreed to send out the flier to all of my classmates. The survey was active for approximately one week, and in that time 189 individuals participated in the survey.

Outcome and Explanatory Variables

The attitudes of participants regarding physician assisted suicide will be measured by their responses to the age and gender demographics for terminally ill patients. The type of illness will not be specified and will remain unchanged throughout the survey in order to ensure that the type of illness will not be a variable which alters the opinion of the participant. If the illness were to be specified or altered throughout there is an increased chance that the participants would resonate with a particular sickness over another, which would skew the results. The outcome

variable will be the accounted for through the participant’s responses and their attitudes towards physician assisted suicide as a result of the patient vignettes. This will be analyzed by averaging the results of the survey. The explanatory variable is the demographic attributes of the theoretical patients that will change throughout the patient vignettes to represent varying genders and ages. This variable will be measured by the participant responses in order to identify which demographic, if any, affects the overall attitude toward PAS. This study seeks to understand if a demographic aspect will alter a person’s attitude on the use of physician assisted suicide, so changing the age or gender of patients with the same illness will showcase its impact.

Analytical Strategy

In order to analyze the data, the reports tool on the Qualtrics software which was used for the survey will be utilized to organize responses. The section of the survey which was used to gather information about respondents will be analyzed in order to better understand the people who participated and their perspectives. Due to personal limitations on statistical knowhow there will not be advanced statistical analysis of the results. Instead, the quantitative aspect of the study will be shown through finding the mean of responses. A qualitative approach will be applied to the analysis of the survey as well. The qualitative approach will be used to analyze the differing responses to the patient vignettes, as well as the comment section at the end of the survey.

Research Issues

One ethical issue that may arise through this research is that of informed consent. Due to the online nature of the survey it is possible that participants will feel obligated to finish the survey despite feeling uncomfortable with its content. This issue was controlled by the information section at the very beginning of the survey where participants were warned about the

potential risks and discomforts of the study, and given the knowledge that they could leave the survey at any time should they wish. Participants were also given the option to consent to participate or not before the survey began. No financial incentive was offered, so this decreased the chances that individuals would feel pressured to complete the survey due to the aspect of money. Also, because individual professors spread the survey to their students, there was a risk that those students would feel pressured to complete the survey or they would face repercussions in the class. This issue, however, was decreased as well because each of the professors noted in their email to the entire class that the survey was not a requirement of the course, and therefore would not impact their course grade. Confidentiality is also an ethical standard that was of some concern for this study. Participants should feel confident that their responses will be kept private by the researcher, particularly because responses to this survey may be considered controversial. The topic of physician assisted suicide can be a sensitive and divisive subject. In order to remedy this ethical concern the survey was kept anonymous, and no names or other identifiable information was asked for as a requirement of the survey.

There are some limitations which face the research data. A limitation of this data could be that the sample size is fairly small, and therefore cannot be generalized to the broad public. The purpose of this project is to see what participants think about physician assisted suicide, how patient demographics affect their attitudes, and if the practice could possibly be legalized in more states throughout the U.S. The University of Wyoming is made up of students from all across the country, and because of this the survey could not be limited to residents from a particular state. Because of this, getting an accurate representation of the future of this medical practice in any particular state could be difficult. Also, because of the independent and unsupervised nature of the survey it is impossible to control who participates. Some individuals could have been

dishonest about their age in order to participate, which would skew results. There should also be considerations made that because the survey is unsupervised participants could select responses at random, not really caring about the questions. If this were to happen the integrity of the data would be called into question.

Another consideration that should be made for this data is the lack of generalizability. The research includes nonprobability sampling techniques, so the results will not be generalizable to other states across the nation. The results will be representative of only a smaller population because the sampling size is not large enough to equate to larger representation. However, this research project is not done with the intention of comparing it to other states where PAS is not legal yet, but to gain an understanding of the attitudes of the average person.

Results and Analysis

Respondents

The total number of participants for the survey was 182 individuals. The average age of respondents was 33 years old, and there was a range of ages for participants, from 18 years old to 80 years old. A majority of the participants identified as white, non-Hispanic, heterosexual, female, and Christian. Also, a majority of participants had completed some level of higher education. The participants were split between those who are single and those who are married or partnered and cohabitating. The table below demonstrates the responses to the survey questions regarding personal background. The demographic variables of significance are listed, along with the percentage and number of responses to each aspect of the multiple-choice question.

Table 1.0

Demographic Variables	Percentage (%)	Number (n)
Hispanic Non-Hispanic	7.14% 92.86%	n = 13 n = 169

White Non-White	92.31% 7.69%	n = 168 n = 14
Currently Married Never Married	38.46% 56.04%	n = 70 n = 102
Single Partnered, Cohabitating Partnered, Non-Cohabitating	30.39% 44.20% 20.99%	n = 55 n = 80 n = 38
Female Male	76.37% 23.63%	n = 139 n= 43
Heterosexual Gay Lesbian Bisexual	87.91% 1.65% 1.65% 6.59%	n = 160 n = 3 n = 3 n = 12
Christian Muslim Jewish Buddhist Atheist Agnostic Other	58.56% 0% 0% 0% 12.15% 22.10% 7.18%	n = 106 n = 0 n = 0 n = 0 n = 22 n = 40 n = 13
High School Graduate/GED Some College 4 Year College Graduate Graduate School Training	6.59% 53.85% 17.58% 21.98%	n = 12 n = 98 n = 32 n = 40

Patient Vignettes

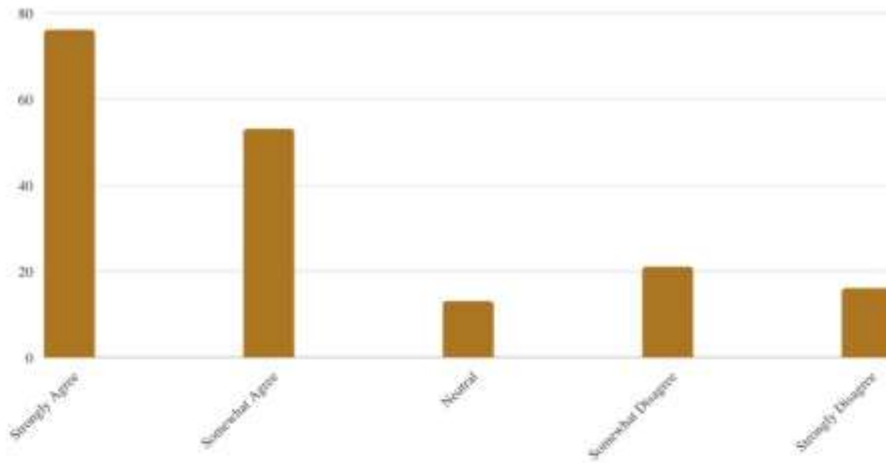
There were 5 patient vignette questions, set in place to give the participant a more personalized, individualistic example of a death with dignity situation. The vignettes were simple in nature so as not to over-complicate the thinking of the participant. Instead of setting forth a detailed and complex vignette, a simpler format was chosen so that the baseline attitude from the participant could be measured better. The participants were asked to use an ordinal scale of “strongly agree” to “strongly disagree” when considering whether it is acceptable for the given patient to be able to utilize physician assisted suicide. Overall, the participants had positive attitudes towards the utilization of physician assisted suicide for all of the patient vignettes. Figure 1 shows the controlled patient vignette, where the individual is not given a gender or age,

but is known to have a terminal illness and a 6 month prognosis. In Figure 1, 42.46% (n=76) of participants strongly agreed and 29.61% (n=53) somewhat agree that the patient should have access to physician assisted suicide services, while 8.94% (n=16) participants strongly disagree and 11.73% (n=21) somewhat disagree. 7.26% (n=13) remained neutral. Figure 2 demonstrates the responses of participants when faced with a 30 year old woman with an unidentified terminal illness and a 6 month prognosis. Similar to the results of the first patient vignette, a majority of respondents had positive attitudes towards this patient utilizing PAS. 39.66% (n=71) participants strongly agree and 31.84% (n=57) somewhat agree that PAS is acceptable in this circumstance, while 10.61% (n=19) strongly disagree and 12.85% (n=23) somewhat disagree. 5.03% (n=9) of respondents chose to remain neutral. Figure 3 demonstrates yet another patient vignette, very similar to the last, however while the theoretical patient remains female, her age is changed to be 85 years old. With this, 59.44% (n=107) of participant strongly agree that PAS is an acceptable option for this patient and 19.44% (n=35) somewhat agree; on the other side, 9.44% (n=17) of participants strongly disagree and 5.56% (n=10) somewhat disagree. There is a slight shift that is noticeable in the attitudes of participants towards the use of physician assisted suicide between the female patients. The 85 year old woman has slightly higher approval than the 30 year old woman, as participants altered their attitudes due to her age.

The patient vignettes shift gears by altering the gender of the patient to male instead of female. Like the control patient vignette and the two different vignettes based off of a female patient, the male patients also resulted in an overall positive attitude towards physician assisted suicide. Figure 4 shows the results of the patient vignette with a 30 year old man, with the same unidentified terminal illness and 6 month prognosis. The results show that 40.00% (n=72) of participants strongly agree that physician assisted suicide is acceptable for this circumstance and

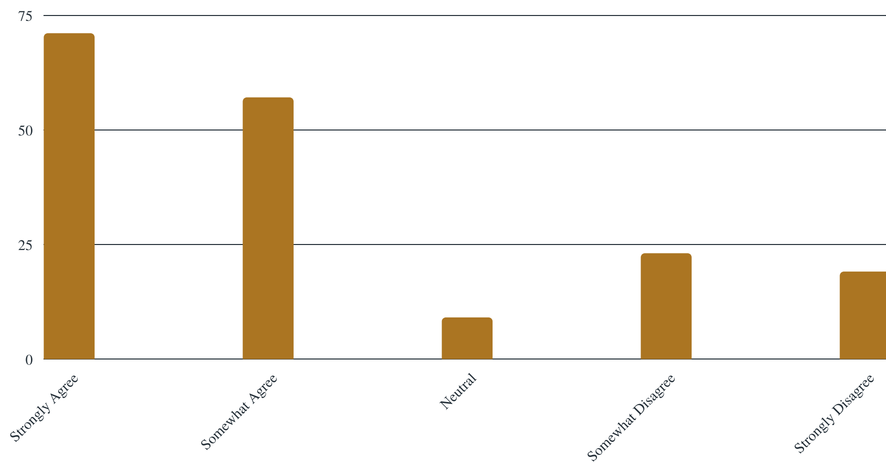
32.22% (n=58) somewhat agree. 11.11% (n=20) of participants strongly disagreed and 12.22% (n=22) somewhat disagreed that the young man should use PAS; 4.44% (n=8) of participants remained neutral. Lastly, Figure 5 showcases the patient vignette with an 85 year old man who has the same unidentified terminal illness as the rest, and the same 6 month prognosis. Under these circumstances, 58.89% (n=106) of participants strongly agreed that it would be acceptable to utilize PAS and 20.00% somewhat agreed; on the other hand, 9.44% (n=17) strongly disagreed and 5.56% (n= 10) somewhat disagreed. 6.11% (n=11) of the participants chose to remain neutral. Just as the patient vignettes with the female demographics and varying ages showed, the age of the patient resulted in a slight shift towards higher approval for its utilization on the 85 year old man. When comparing the four patient vignettes from the perspective of gender, there is no obvious or significant change in attitude from respondents. Because of this, it is clear that gender does not have a significant impact on the attitudes of participants. However, when viewing these patient vignettes from the perspective of age, there is a small, yet clear, change in attitude from respondents.

FIGURE 1



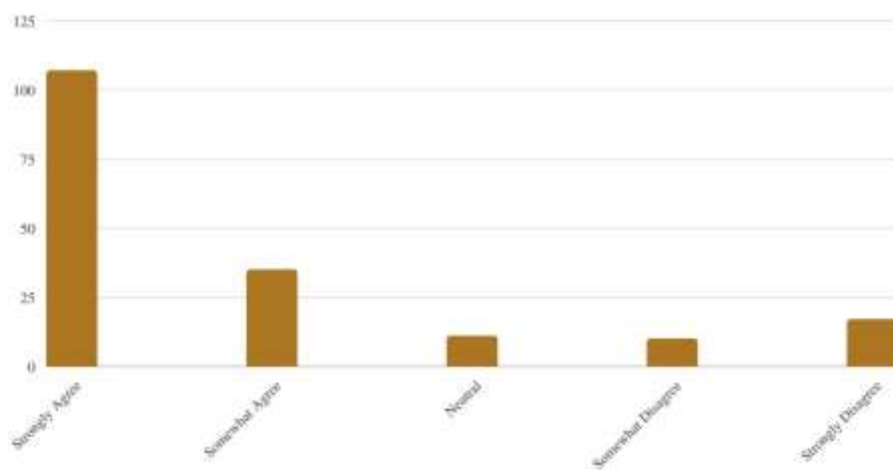
(Patient Vignette #1: An individual has been diagnosed with a terminal illness and given a 6 month prognosis)

FIGURE 2



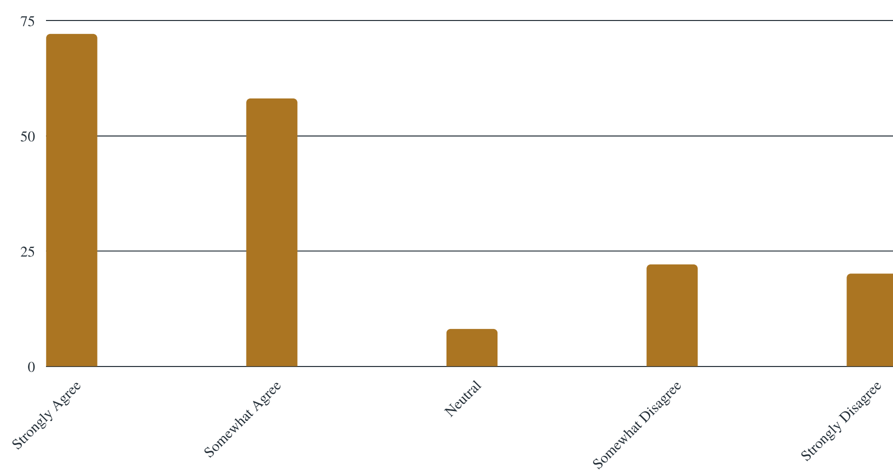
(Patient Vignette #2: A 30 year old woman has been diagnosed with a terminal illness and given a 6 month prognosis)

FIGURE 3



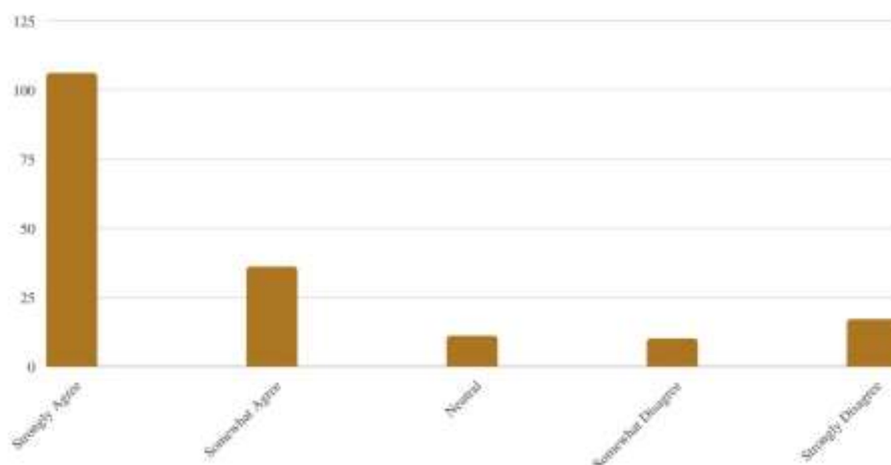
(Patient Vignette #3: An 85 year old woman has been diagnosed with a terminal illness and given a 6 month prognosis)

FIGURE 4



(Patient Vignette #4: A 30 year old man has been diagnosed with a terminal illness and given a 6 month prognosis)

FIGURE 5



(Patient Vignette #5: An 85 year old man has been diagnosed with a terminal illness and given a 6 month prognosis)

Table 2.0

Patient Vignette #1	Strongly Agree = 42.46% (n = 76) Somewhat Agree = 29.61% (n = 53) Neutral = 7.26% (n = 13) Somewhat Disagree = 11.73% (n = 21) Strongly Disagree = 8.94% (n = 16)
Patient Vignette #2	Strongly Agree = 39.66% (n = 71) Somewhat Agree = 31.84% (n = 57) Neutral = 5.03% (n = 9) Somewhat Disagree = 12.85% (n = 23) Strongly Disagree = 10.61% (n = 19)
Patient Vignette #3	Strongly Agree = 59.44% (n = 107) Somewhat Agree = 19.44% (n = 35) Neutral = 6.11% (n = 11) Somewhat Disagree = 5.56% (n = 10) Strongly Disagree = 9.44% (n = 17)
Patient Vignette #4	Strongly Agree = 40.00% (n = 72) Somewhat Agree = 32.22% (n = 58) Neutral = 4.44% (n = 8)

	Somewhat Disagree = 12.22% (n = 22) Strongly Disagree = 11.11% (n = 20)
Patient Vignette #5	Strongly Agree = 58.89% (n = 106) Somewhat Agree = 20.00% (n = 36) Neutral = 6.11% (n = 11) Somewhat Disagree = 5.56% (n = 10) Strongly Disagree = 9.44% (n = 17)

Qualitative Data

The last section of the survey offered a surprising amount of qualitative data. Many participants utilized the additional comments and opinions section to speak on their beliefs when it comes to the utilization of physician assisted suicide. As seen through the quantitative data, a majority of the respondents believe that it is acceptable to use this type of medical practice, and therefore hold positive attitudes towards it. However, there were several comments in this portion of the survey that spoke out against physician assisted suicide- bringing up worries about its misuse and the negative impact it could have on society.

When looking at the positive comments for the use of PAS participants brought to attention several key arguments for the legalization of this medical practice. Several participants believe that all individuals should have the right to determine their own end-of-life decisions in order to maintain dignity and autonomy over themselves and their bodies. One participant compared the discussion of PAS, in terms of deciding what exactly someone wants to put their body through, to that of the pro-choice argument, stating:

"If we go off of abortion logic, it's their body, their choice."

By utilizing "abortion logic" a person should have complete control over their own body, and medical decisions should not be impacted by government policy or religious ideologies. Other participants who held positive attitudes towards physician assisted suicide based their reasoning off of not wanting the patient to experience excessive pain or discomfort. They also tend to use

external factors such as already having lived a full life, or not having any family to be there for you as justifications for the practice. One participant reasoned her support for PAS by saying:

> "I believe that Physician Assisted Suicide is complex and a lot goes into it. I believe a person should always be persuaded to live and not commit suicide but if you have lived a long life and have no loved ones or if you are going to suffer, I think there is reason for it."

Physician Assisted Suicide is reserved for those more extreme cases, and from the results of the comment section it is clear that many respondents feel that it should be implemented throughout the country. All of the pain and discomfort endured by the patients, as well as the strain it puts on family relationships and finances, is not worth the end result. Maintaining a sense-of-self and autonomy until death appears to be important to a majority of the respondents.

On the other side of this argument, there are several survey participants that do not believe physician assisted suicide should be implemented. Some have argued that misdiagnoses and malpractice would result in the untimely deaths of people, and the risks that come with legalizing PAS are too great. One respondent stated:

> "Their lives are worth more than being ended over some doctor's diagnosis. Malpractice is a huge problem in the United States and doctors can often incorrectly give prognoses to people."

To many participants, the reliance on doctors to make proper diagnoses and prognoses is the downfall of physician assisted suicide. Others, however, also argue that by approving medical practices such as this, our society will de-value human life. Society is rapidly changing throughout time, and some of the survey participants noted that if a concession is made to allow certain people to end their lives, then it will open a door to other concerning practices that will result in the degradation of our culture. A comment made by one of the participants who took a negative attitude towards physician assisted suicide reasoned their stance by saying:

> "I think if human life is of value to our society, ending a life with PAS is riding a fine line about what is acceptable and not in our society. I think there are probably cases where the individual is in so much pain and is so disheartened they are ready to die. But where as a society do we decide the line is for assisted deaths? I think PAS is very beneficial in some cases, but I always somewhat disagree because I just think there is value to human life that extends beyond our own knowledge."

There were diverse arguments made for and against physician assisted suicide, however despite the inclusion of negative attitudes towards PAS a large majority of participants viewed the medical practice with positive attitudes. When discussing the implementation of physician assisted suicide in combination with patient demographics like gender and age, many respondents felt that those aspects should not be a significant factor in deciding whether or not physician assisted suicide should be utilized. One participant expressed this belief by stating:

> "Age and gender should not be important to the choices of people in regards to Physician Assisted Suicide because it does not play a factor in the illness that is terminal."

Overall the results of the qualitative data provided by the comment and opinion section of the survey provide evidence which suggests that a majority of people hold positive attitudes towards physician assisted suicide, and the patient demographics of gender and age do not impact this.

Discussion

Findings

Through the conclusion of this study I found that participants were more accepting of physician-assisted suicide for the terminally ill patients with older age demographics than those who were younger. There is an assumption that the hypothetical patients in the older age bracket were viewed as already closer to death, and therefore the acceleration of death through medical means was not considered unnatural. The patients within the younger age bracket were viewed as still having potential by some respondents, as they have not experienced many important life events. Because of this, a smaller portion of the respondents were less inclined to accept their

wish for PAS. I also found that participants were not greatly affected by the demographic of gender in accepting physician assisted suicide for terminally ill patients. Male and female subjects were utilized in the vignettes, but the respondents did not place an unbalanced amount of favor on one gender over the other. Because the average age of respondents was 33 years old, it can be concluded that the sampling of a younger generation results in the illustration of slightly different cultural norms. Younger populations tend to be more accepting of men and women as equals, so their requests for physician assisted suicide did not affect the responses. Lastly, I found that, overall, participants were accepting of physician assisted suicide, despite any changes in demographics. With patient vignettes boiled down to only the necessary information, with no other details to alter opinions, a large majority of the respondents were more supportive of patients maintaining their peace and autonomy.

Implications

The findings from this study identify a connection between perspectives on demographics and physician assisted suicide, which is important when considering legalizing PAS throughout the country. Depending on how accepting respondents are of physician assisted suicide, or other mechanisms similar to it, there may be a future adoption of these practices in more states across the country. The legalization of physician-assisted death is slowly spreading throughout the United States, and the individuals being surveyed are the voters that will have a fresh perspective to policy reform. If PAS is positively received through this study, then policy in places such as Wyoming could change to allow residents their right to die with dignity. The legalization of these laws would give independence to terminally ill patients and help those who are struggling at the end of life to maintain their autonomy and their dignity.

Conclusion

These results provide an insight into the attitudes held by people from various age groups and personal backgrounds on the subject of physician assisted suicide. It is important to examine the attitudes of people who are of voting age in order to understand in what way they view interaction between patient demographics and physician assisted suicide. Age or gender might be impactful to their decision on if, or when, physician assisted suicide is an acceptable practice. Older patients with serious illnesses who are seeking PAS would be more likely to have their requests deemed acceptable because it is more in line with societal norms for the young to maintain life and the old to pass on. Aspects such as gender do not impact attitudes towards physician assisted suicide, most likely due to the fact that society has rapidly increased its ability to view men and women equitably so that no one gender is prioritized over another. Overall, the results of this study indicate positive attitudes towards physician assisted suicide, and the viability of death with dignity laws.

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