8-1-1999

Attitudes Concerning Euthanasia Among Protestant Denominations

Greg Morgan
Western Kentucky University

Attitudes Concerning Euthanasia among Protestant Denominations

A Thesis

Presented to

The Faculty of the Department of Sociology

Western Kentucky University

Bowling Green, Kentucky

In Partial Fulfillment

of The Requirement for the Degree

Master of Arts

by

Greg Ryan Morgan

August 1999

Attitudes Concerning Euthanasia
Among Protestant Denominations

Date Recommended 7/9/99

Dawson Clayton Smith
Director of Thesis

Stephen B. Groce

Joan Krenzin

Elmer Gray
Director of Graduate Studies

8/10/99
Date

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Attitudes Concerning Euthanasia
among Protestant Denominations

Greg Ryan Morgan August 1999 86 pages

Directed by D. Clayton Smith, Joan Krenzin, Steve Groce

Department of Sociology Western Kentucky University

The purpose of this research was to uncover differences in attitudes among Protestant denominations concerning euthanasia. Variations in attitudes were viewed using social theories of religion by Emile Dukheim, Max Weber, Charles Glock, and Rodney Stark. These theories were used to establish a basis for variation among the Protestant denominations on social issues. A questionnaire was given to four Protestant Churches in a mid-sized city in Kentucky during the Spring of 1999. The sample of 134 respondents represented six different Protestant denominations. Logistic regression and factor analysis were used to analyze the data. Results suggest that pro-euthanasia attitudes are positively correlated to educational attainment, experience with a dying friend, and association with liberal denominations. The results also suggest that pro-euthanasia attitudes are negatively correlated with religiosity and political conservativism.

ACKNOWLEDGMENT

I would like to thank Dr. D. Clayton Smith, Dr. Joan Krenzin, and Dr. Stephen Groce for their support and advise during this thesis project. They worked hard to ensure that the thesis would be a quality piece of research. This thesis would not have been possible without them.

I would like to thank my fellow graduate students for their support and patience with me. It was nice to have people who could relate to the pains of research from my point of view.

CHAPTER 1

INTRODUCTION

On March 7, 1991 an article by internal medicine specialist Dr. Timothy Quill was published in the *New England Journal of Medicine*. In this article Dr. Quill admitted providing a terminally ill patient with a prescription that she used to take her life. Quill indicated that for years other physicians he knew had covertly provided terminally ill patients with the means to end their lives. The New York State Health Department investigated Dr. Quill; but because he had not taken any action in the death of the patient, he was not sanctioned (Gorman and Roberts 1996; Quill 1994).

Through his admission Dr. Quill became a leader in the movement for the right of individuals to die with dignity. He believes that these rights are best practiced through palliative care or Hospice organizations, but should only be considered when all other means of relieving suffering fail (Quill 1994).

Perhaps the most notable figure in the euthanasia movement is Dr. Jack Kevorkian. Kevorkian has been an advocate of physician-assisted suicide since the 1950s.

Although trained as a pathologist, his obsession with research centered around death soon ostracized him from the medical community. Most of Dr. Kevorkian's time during the 1980s was devoted to the design of his suicide machine, the mercitron. The mercitron is a simple device in which Kevorkian runs a saline solution from the machine into the patient through an IV. It is then up to the patient to turn a switch releasing thiopental through the IV unit and at the same time starting a timer. The thiopental induces sleep in the patient. When the time expires, potassium chloride is released into the IV, which stops the patient's heart (Gorman and Roberts 1996).

The mercitron is a more active form of euthanasia. Because of the mercitron, and the fact that unlike Quill Kevorkian did not know his patients on a professional or personal level, many people involved with right-to-die organizations blame Kevorkian for causing the current controversy over the right-to-die issue. Because of his strong ideological stance in favor of active euthanasia, Kevorkian has assisted in over 40 physician-assisted suicides, several of which have led to trials for murder. As such, Kevorkian is the person most associated with euthanasia (Gorman and Roberts 1996).

Yet, a more typical euthanasia case is that of television anchorman Hugh Finn. In March 1995 Finn was

involved in a car crash in Louisville, Kentucky. The accident ruptured Finn's aorta, causing his brain to be deprived of oxygen. Finn was in a persistent vegetative state (PVS) after the accident. He received artificial nutrition for more than three years. Doctors stated that Finn had little to no chance of recovery.

His wife, Michele, wanted to have the feeding tube removed and let him die. A Virginia judge granted her permission to carry out the removal of the feeding tube but gave other relatives until September 30, 1998 to appeal the decision (Hopper 1998a, p. 2). Despite a report on September 18, 1998 from a nurse that Finn had said "hi" to her and later smoothed his hair, six doctors testified that Finn was in a persistent vegetative state and would not recover. The family members who were opposed to removing Finn's feeding tube issued a statement on September 29, 1998 that they would not appeal the decision because they believed that Finn would not want to live in his present state (Hopper 1998b, p. 1).

Finn's feeding tube was removed on October 1, 1998. Finn had spent the last few years in a nursing home in Manassas, Virginia.

The twentieth century has seen the birth of many new medical technologies and ideologies. It was only eighty

years ago that penicillin was discovered. With its introduction many new miracle drugs and treatments soon followed to help people live longer and healthier lives. Who could have predicted that the science of maintaining life would be called into question at the end of this century?

The emergence of euthanasia as an alternative to natural death is directly related to the increased life expectancy of individuals in our society. Because of improved health care America now has a rapidly growing population of individuals 85 years old and older. The U.S. Census Bureau has named this group the "oldest old" and has shown this group to be the fastest growing age group in the United States.

Census data show that from 1960 to 1994 the "oldest old" have increased 274 percent. Moreover, in the 1950 census 4,475 people were recorded as being over 100 years old. By 1990 the number had increased to 54,000 (Coakley and Maguire 1997). The "oldest old" numbered 3 million in 1994. It is projected that the number will increase to 19 million by the year 2050. The number of people over 65 years old is predicted to double to 80 million by 2050. This projection means that 20 percent of the population could be made up of the elderly in 2050 (U. S. Census Bureau 1995).

There has also been an increase in the completion of living wills over the last two decades (Armstrong, Singer, Choudhry, Meslin, and Lowery 1995). The living will is a directive completed by a competent person. The will often must be signed before he or she is medically treated. This directive informs healthcare providers of the patient's wishes in the event that he or she becomes irreversibly ill and incompetent (Hemlock Society 1995).

Improved health-care techniques have not only lengthened the lives of many persons but have also changed the top killers of our society from causes that were infectious to chronic diseases. In 1900 the top killers were influenza, tuberculosis, and gastritis (Thomlinson 1976, p. 122). In 1997 the top killers were heart disease, cancer, and cerebrovascular diseases such as strokes. (National Vital Statistic Reports 1998, p. 7).

All three of these new top killers have the potential to be both chronic and terminal illnesses, and all three can be physically and mentally painful. For example, throat and lung cancer in their final stages are reported to cause patients to feel that they are suffocating (Quill 1994). The Hemlock Society, a group pushing for the legalization of euthanasia, defines the people suffering from this kind of illness the "irreversibly ill." This

term is different from terminally ill because it implies a "lengthier dying process" (The Hemlock Society 1995).

Euthanasia presents an unusual problem to sociology. It is a phenomenon that represents the ultimate dysfunction in modern health-care. People are living longer than they have in the past and as a consequence are now suffering from more chronic diseases. The researcher believes that those patients who choose euthanasia are those who believe that being kept alive is distinctly different from living. The study of euthanasia is important to sociology when it is considered how quickly our society embraced such an extreme action as an alternative to "natural" death. Few sociologists have studied what the social factors are that influence people's opinions of euthanasia.

This study examined the effects of religious denomination, religiosity, education, socioeconomic status, and personal experience with a dying friend or relative on attitudes concerning euthanasia. It was believed that a higher acceptance of euthanasia would be found among those persons involved with liberal denominations, with higher levels of education and socioeconomic status, and with experience with a close friend or relative dying from a terminal illness.

This subject was examined using the theories and concepts of Max Weber, Emile Durkheim, and Charles Glock and Rodney Stark. The ideas about Protestant beliefs concerning euthanasia were taken from the above theorists works on the subject of religion.

Surveys were used to examine the thoughts of members of four different religious denominations concerning their opinions on euthanasia. This survey also collected demographic data in order to test for other variables that might influence people's opinion of the acceptability of euthanasia. The findings will aid in the study of what factors influence the opinions of euthanasia and give a better understanding as to how socially acceptable this uncommon practice really is.

CHAPTER 2

LITERATURE REVIEW

"Euthanasia" comes from the Greek word *euthanotos*, which means easy death (Gorman and Roberts 1996). In our society it has taken on more interesting meanings. The word euthanasia is associated with mercy killing, physician-assisted suicide, medical murder, death with dignity, and termination of life support. The basic meaning implies a merciful and relatively painless ending of a terminally ill person's life.

The idea of euthanasia has been stated several ways. It is important to note how the concept is used because its phrasing has been found to coincide with its acceptance. Huber, Cox, and Edelen (1992) found that the term "physician-assisted suicide" was less favorably received than were the terms "euthanasia," "mercy killing," or "some form of personal control over death."

One of the major debates coming from previous cases concerns the question of whether removing a feeding tube is active euthanasia or passive euthanasia. Passive euthanasia is "the deliberate disconnection of life support

equipment, or cessation of any life-sustaining medical procedure, permitting the natural death of the patient" (The Hemlock Society 1995). The Hugh Finn case would be an example of passive euthanasia.

Active euthanasia is defined as the "deliberate action to end the life of a dying patient to avoid further suffering" (The Hemlock Society 1995). Active euthanasia can be voluntary or involuntary. Active voluntary euthanasia is ending the patient's life at his or her request. Physician-assisted suicide, as practiced by Kevorkian, is the best known form of active voluntary euthanasia. Active involuntary euthanasia is ending the patient's life without his or her permission (The Hemlock Society 1995).

The most infamous case of active involuntary euthanasia was practiced in pre-World War II Germany by the Nazis. The Nazis killed the hopelessly ill, the handicapped, and the mentally retarded patients of state run hospitals. This action was reportedly done to ease the burden on state funds. Many historians see this action as the precursor for the Holocaust (Gorman and Roberts 1996). For the purposes of this study the researcher will be concerned only with voluntary euthanasia, both passive and active.

Achille and Ogloff (1997) have shown that survey

respondents differentiate between active and passive euthanasia. The researchers indicated that people seemed to define "letting die" as more acceptable than assisted-suicide.

The Ethical and Legal Dilemma

Peter Singer (1979) has argued that statements about the sanctity of human life lose much of their standing when religion is removed as an issue. He argues that while human life itself is one of the most advanced forms of life on earth, it is not any more sacred than the life of another animal. While he believes rules should be maintained in a society, he advocates that the population should lose the sense of sanctity of human life and address humans as members of a species of animals.

In a similar manner, Fletcher (1975, p. 45) believes that "we should drop the classical sanctity-of-life ethic and embrace a quality-of-life ethic instead." Fletcher downplays the importance of biological survival and emphasizes the importance of personal integrity. He feels that the medical community is in error in believing that it is always best to preserve life. There is also an argument that active euthanasia should be redefined because it is merely freeing a patient from a natural, yet painful, state of existence (Hopkins 1997).

According to Quill (1994) most medical personnel believe that the disconnection of a feeding tube is passive euthanasia. He argues that doctors believe that a patient taken off other forms of life sustaining equipment (i.e., respirator) potentially can live. However, many right-to-die activists point out that the brain damage like that present in the Finn case does not allow the patient to swallow on his own. Therefore, they contend that the cessation of artificial nutrition will allow the natural death of the patient (Cantor 1989).

In either case, the American Medical Association (AMA) still rejects the practice of euthanasia. The main concern of the AMA is that "new practices bring new abuses" (Post 1991, p. 61). One of the fundamental themes in the Hippocratic Oath is that the doctor should not harm the patient. The traditionalists in the medical profession would rather live with the suffering that accompanies the irreversibly ill than to replace it with a "new evil" (Post 1991, p. 58).

The United States is not the only nation grappling with this issue. Physicians in the Netherlands have been at the forefront of the euthanasia movement for more than a decade. At the present time the Netherlands does not prosecute physicians who participate in the practice of euthanasia. The experience in the Netherlands has so far

shown that the acceptance of the practice of euthanasia has not raised the overall suicide rate (Forde, Aasland, and Falkum 1997). In fact, research has shown that the age groups "old" and "old old," which have the most incidences of terminal disease in the Netherlands, have not had a significant increase in their suicide rates (Zalman and Stack 1996). Early efforts in this country appear to show the same results. Nor has the passage of assisted dying laws in Oregon been the prelude to an invasion of terminally ill persons into that state (McKhann 1999).

The AMA Council on Ethical and Judicial affairs, the President's Commission on Ethical Problems in Medicine, and the Hastings Center all consider life prolonging treatments such as artificial nutrition and respirators as treatment that in the case of the irreversibly ill may be discontinued (Cantor 1989). But, if the patient or his or her family and the physician disagree about the termination of life prolonging treatment, then the patient or proxy has the right to settle the case in the state court (Hanks 1995).

The Board of the American Association of Suicidology, a group devoted to the study and prevention of suicide, selected a committee to study euthanasia in 1994. The recommendation of the committee after two years of research

was that the American Association of Suicidology "take no position" on the subject of euthanasia or its legalization (American Association of Suicidology 1996, p. 2).

The decision not to accept life sustaining medical treatment in the case of the irreversibly ill is not the same as suicide (CeloCruz 1992). The court has established case law in which the refusal of life prolonging medical treatment is acceptable. Withholding life sustaining medical treatment at the request of the competent patient is different from assisted suicide. There are currently no state or Federal statutes that punish people who attempt suicide. There are 30 states and two U. S. territories that have punishable statutes against the aiding or promoting of suicide (CeloCruz 1992). Forty Four states criminalize assisted suicide through statutory or common law (Churchill and King 1997).

The cases of Jack Kevorkian and Timothy Quill present similar legal problems. Kervorkian was first tried in Michigan, and at that time there were no clear laws concerning euthanasia. Kervorkian is currently imprisoned for directly causing the death of a patient by giving him a lethal injection. Quill was tried in New York, a state that did have statutes against physician assisted suicide. The court was hesitant to convict Quill although he did assist in the suicide of one of his patients at her

request. The speculation among many conservative followers of these trials is that society tolerates euthanasia in extreme cases (CeloCruz 1992; Gorman and Roberts 1996; Quill 1994).

Bills introduced in California and Washington state that were intended to legalize passive euthanasia and physician-assisted suicide (PAS) were only narrowly defeated. CeloCruz (1992) states that the main reasons they were not passed is the lack of safeguards and the fear of abuse. Washington state's proposal received 46 percent of the popular vote. It is interesting that the Pacific states would be the first to introduce such bills when past research among college students has shown higher acceptance of euthanasia on the East Coast than on the West Coast (Adams, Bueche, and Schvaneveldt 1978).

Some polls indicate that between 50 and 75 percent of the population are in favor of euthanasia and physician-assisted suicide when the patient is terminally ill and suffering from excruciating pain (Churchill and King 1997; Quill 1994). A study conducted of the public and of medical doctors in Michigan indicate that some forms of assisted-suicide are acceptable under certain conditions. In the survey 56% of the medical doctors indicated that assisted-suicide with guidelines should be legalized.

Sixty six percent of the public surveyed indicated that assisted-suicide with guidelines should be legalized. However, 52% of the doctors surveyed stated that they would not assist in suicide if it were legalized (Bachman, Alcser, Doukas, Lichenstein, Corning, and Brody 1996, p. 306).

Euthanasia and Society

It is important to realize that euthanasia is not an issue of the future. It is an issue that is here. A survey conducted by the American Society of Internal Medicine reported that "one in five physicians say they have deliberately taken action to cause a patient's death" (Meier, Emmons, Wallenstein, Quill, Morrison, and Cassel 1998). It is estimated that 70 percent of the deaths in hospitals are based on a doctor-patient agreement. A study conducted in Washington indicated that 24 percent of the physicians who were requested to aid in the patients' dying responded by providing a prescription that would painlessly end the patients' lives. Thirty nine percent of these patients receiving this prescription opted not to take it (Back et al. 1996, p. 922).

> [These] deaths are eventually planned or negotiated in some way, usually when the burdens of continued treatment far outweigh the benefits. The most common methods of assisting death are indirect--stopping or not starting a potentially effective treatment, or by using high doses of opiod analgesics to ease suffering at the very end....In addition, most

> patients who choose treatment under such circumstances [terminal cancer] don't adequately inform themselves about the most likely outcome--that they will die in the midst of very arduous treatment. (Quill 1994, p. 318)

A survey of 1,139 nurses revealed further evidence of euthanasia involving medical professionals. Sixteen percent reported that they had engaged in euthanasia. Four percent reported that they had pretended to give life-sustaining treatment to an irreversibly ill patient, when in fact they had let the patients die at their own request (Asch 1996).

A study conducted of nursing homes in Minnesota, Wisconsin, and Indiana revealed that 70 percent of the nursing homes would withdraw life-sustaining treatment at the request of the competent patient or family. Twenty four percent indicated that they would halt life-sustaining treatment even without a court order (Almgren 1993, p. 60).

Doctors have cited that the main considerations in whether or not they would participate in physician assisted-suicide are the symptoms and expected survival of the patient (Back et al. 1996).

The public seems to have two concerns that are improving the receptiveness of euthanasia. These concerns are the desire not to be a physical or financial burden on loved ones (Fung 1993; Hardwig 1997) and the desire to have a painless death (Bachman et al. 1996; Gelo, O'Brien, and

O'Connor 1997; Holden 1992; Werth 1999).

Euthanasia and Religion

Some of the strongest opposition to euthanasia comes from the Christian community. In fact, Kohl (1974) suggests that our attitudes toward euthanasia, as a moral issue, are affected by theological ideas such as human life being a gift from God. Those who oppose euthanasia based on religious beliefs typically cite the sixth commandment as proof that God forbids it. The traditional translation of the sixth commandment is "Thou shalt not kill." One translation from the Greek Bible is "Thou shalt not commit murder" (Rachels 1986). This translation may be interpreted as forbidding wrongful killing only. The latter translation is often used by religious philosophers who argue that some forms of euthanasia are permissible to the church.

Many Christians belonging to fundamentalist denominations believe that euthanasia in any form is wrong. Holden (1992) found that the California Pro-Life Counsel had a strong representation from the Catholic community. The Catholic church has had doctrines against euthanasia since the time of the Roman Empire.

> Acts of suicide were called "felo de se"--self murder--and the church made no distinction between an emotional act of suicide and choosing to die because of a prolonged, terminal condition. Suicide

> in any form was strictly forbidden by the church because it held that God's will alone should determine life and death, and human interference was sinful. (Gorman and Roberts 1996, p. 6)

Yet, Pope Pius XII did write that it is not right to unnaturally prolong life in terminal situations (Burnell 1993; Carter 1993). In the Vatican *Declaration on Euthanasia* of 1980 the clergy worded the definition of euthanasia to include not taking action that would prolong a patient's life. This redefined the disconnection of life-sustaining treatment as killing in the view of the Catholic church. Likewise, the refusal of the patient to start treatment is considered suicide (Gula 1986) The people holding "fundamentalist religious views" are more likely not to accept passive euthanasia, even in the form of choosing to forego treatment (Somerville 1996, p.x). Many religious fundamentalists believe that all possible means should be used to keep a person alive (Somerville 1996). Rachels (1986) contends that because there is no difference in the outcome of passive and active euthanasia, the two are ethically the same. But many religious scholars believe that allowing an irreversibly ill patient to die may be done without violating Christian law (Flynn 1990).

Overall participation in religion is negatively correlated to the acceptance of euthanasia (Adams et al.

1978; Markides 1983). Religiosity has been found to be negatively correlated to the acceptance of euthanasia (Achille and Ogloff 1997). The stronger a person's belief that life belongs to God, the more he or she will be unlikely to support the legalization of voluntary euthanasia (McDonald 1998a). Yet, while the Hemlock Society lacks a significant number of Christian members, it is highly represented in the Jewish community (Holden 1992). The proportion of Jews in the Hemlock Society is ten times greater than the national average. A survey of Oregon physicians' attitudes regarding euthanasia shows that 67 percent of the doctors affiliated with the Jewish religion might participate in physician assisted suicide. This percentage is higher than the physicians with Catholic affiliations (23%) and Protestant affiliations (41%). It should be noted, however, that this question was based on the premise that physician-assisted suicide would be legal and the patients were irreversibly ill (Lee et al. 1996, pp. 311-12).

In another study on various types of suicide Catholics were determined to be the Christian denomination most opposed to euthanasia even when the patient was irreversibly ill (Jordan 1994). However, that research did not differentiate among Protestant denominations.

Glock and Stark (1965) divided the Protestant

denominations into four categories (liberal, moderate, conservative, and fundamentalist) based on the religious interpretation of the Bible and the political and social views held by each denomination. Additional studies have reinforced the idea that different denominations have different views (Caddell and Newton 1995; Hertel and Hughes 1987). Both studies address the religious integration of the individual and the corresponding political view he or she has on death issues. On average liberal Protestants are less integrated into their denominations and are thus more likely to support euthanasia as a way to relieve human suffering in this life. Conservative Protestants tend to be more integrated into their denominations and are less likely to support euthanasia (Caddell and Newton 1995). The American Episcopal church (considered by Glock and Stark to be liberal) has an open interpretation of euthanasia, as stated by the Committee on Medical Ethics.

> When disagreement about a significant issue such as assisted suicide/euthanasia persists, even in light of central Christian teachings, we have a responsibility to explore avenues of common ground as we weigh arguments on all sides. (Committee on Medical Ethics 1997, p. 69)

The Jewish community has strict laws against any type of suicide including active euthanasia. However, passive euthanasia is viewed as permissible (Kaplan and Schwartz 1998). While Jewish Rabbis are far less tolerant of

suicide, there is a more positive attitude concerning suicide among the sick and elderly than suicide for other reasons (Domino 1985). However, any form of suicide is still considered a sin among the Jewish community. Passive euthanasia is accepted only because the person is allowed to die instead of taking an action that would directly end his or her life (Kaplan and Swartz 1998). These facts indicate that religion affects people's attitudes concerning euthanasia on both sides of the debate.

Besides the shift toward chronic illnesses, one possible reason for the increase in attempts to legalize euthanasia is the secularization of the American society. Perrin (1989) relates the decline in mainline church attendance to the change in values of what he calls the "Post-Aqaurian Age." Perrin cites three possible factors to explain this shift in values.

> First a disproportionate number of mainline "baby boomers"...stopped going to church; second, birth rates declined among baby boomers; third the declining church involvement denied the churches the benefit of what natural increase the baby boomers [sic] children would have provided. (Perrin 1989, p. 77)

Peter Berger (1969) further discussed the liberal nature of the Protestant denominations. He cites one of the most liberal aspects of the Protestant denominations as the movement toward secularization. The Protestant

denominations are becoming more secularized in order to align religion with "secularized consciousness" (Berger 1969, p. 168). It may, therefore, be assumed that the more liberal Protestant religions might be more accepting of euthanasia than are other denominations. But, despite the belief of the humanitarian nature of Christianity, there is evidence to show that those with higher religiosity tend to be less humanitarian than the secular society. In fact, the "devout...had more punitive attitudes towards...those who might seem in need of psychological counseling or psychiatric treatment" (Rokeach 1968, p. 190). This statement suggests that while the acceptance of some forms of euthanasia is growing in some Protestant denominations, it will never be as well accepted as it is in the secular society.

Aging, Mental Health, and Euthanasia

Previous research has shown that the public's acceptance of euthanasia depends on the prognosis of the disease. If the individual is irreversibly ill, then the public is more likely to support the end-of-life decisions made by that individual (Armstrong et al. 1995).

Many elderly people consider a "good death" to be without pain and suffering (Gelo et al 1997). Terminal patients in one study also defined a "good death" as pain-free and dignified. The only disagreement on the

subject of a "good death" was whether it is preferable to have knowledge of the coming death or to have death come suddenly (Payne, Hillier, Langley-Evans, and Roberts 1996).

Contrary to what one might expect, pain is only weakly related to the request for euthanasia. The only exception occurs if the patient has a respiratory disease or is suffering from mental distress in relation to his or her terminal condition (Addington-Hall and Seale 1994).

Other research indicates that the public was favorable 80 percent of the time to terminating life support if an advance directive had been given by the patient. The same research indicated an emphasis on the quality of the patient's life. Subjects seemed to favor the ending of treatment for patients who would have a diminished quality of life (Denk et al. 1997, pp. 103-04). Some social workers report that the families of terminally ill patients are often angered by the perception that the medical community wants to "preserve life at all costs." The family members often express a fear of dying with the same illness as the terminally ill, anticipating that they will go through the same suffering while lacking individual autonomy (Werth 1999, p. 247).

The prospect of dying with pain and suffering has created great interest in palliative care and euthanasia.

Even physicians who have participated in some form of euthanasia state that

> physician assisted suicide should not be an alternative to hospice care, but rather should be considered only when hospice care is ineffective, unacceptable to the patient, or when despite it suffering becomes intolerable and irreversible. (Quill 1994, p. 320)

The hopelessness of such situations and the expense of palliative care has caused euthanasia to become a controversial alternative. In an on-line poll of 1,000 senior citizens more than half said they would consider euthanasia if they were irreversibly ill (The Hemlock Society 1995). Branco, Teno, and Mor (1995) found that nursing home residents over 75 years were twice as likely to have a DNR order as were younger nursing home residents. However, other research suggests that many elderly persons want to extend their existence regardless of their physical condition (Cicirelli 1997). Social workers who work with terminal patients report that most are not suicidal (Thal 1992).

Past studies have shown a correlation between demograpic characteristics and attitudes associated with euthanasia. Perhaps the most significant correlation is between age and euthanasia approval. In fact, the older an individual becomes, the more likely he or she is to favor euthanasia for the irreversibly ill (Holden 1992; Singh

1979). A comparison between the members of the Hemlock Society and the California Pro-Life Council indicates that the median age of members of both organizations is 64.9 years for the former and 41 years for the latter (Holden 1992). Even more interesting is the evidence found that attitudes favoring euthanasia increased with age, but attitudes favoring suicide declined with age (Singh 1979). The Hemlock Society members are often widowed or divorced, highly educated, retired, and non-Christian (Holden 1992).

Psychiatrists who evaluate elderly patients are indicating that the patients with depression are being overlooked or not diagnosed properly by their primary care doctors. Less than 20 percent of the elderly patients who are diagnosed with mild to moderate depression are treated with antidepressant medications (Fahy 1997). However, Fahy also states that the elderly patients suffer from an anxiety problem, instead of the apathy that classic psychiatry trains doctors to watch. Extreme cases are easier for a doctor to diagnose, but these cases in elderly persons with mild to moderate depression are not what most doctors learn to expect in training.

The medical schools in this society seems to place little emphasis on training physicians in terminal care. Only five medical schools offer a course in caring for the terminal patient. Only 26 percent of 7,048 residency

programs regularly offer a terminal care course. Fifteen percent of these programs offer no training at all (Morgan and Sutherland 1997, p. 67).

Depression becomes more of a health factor when considering that there is an association between cerebrovascular events (i.e., strokes) and depression. Many patients experiencing this type of depression are not as responsive to medication and often have less chance of optimal recovery from a stroke. There is also evidence that depression can lead to dementia in the elderly. Moreover, it is well documented that persons with depression suffer from more illnesses (Fahy 1997). In a study of 44 terminally ill patients only eleven wished for a premature death. Ten of these 11 patients were diagnosed as having depression (Brown et al. 1986).

The accusations of misdiagnosis and improper treatment should be fully investigated because the implications are that the patients may not have 100 percent of their mental faculties when they are questioned at the hospital. Perhaps less than 20 percent of the elderly patients are receiving the proper treatment (Fahy 1997). This information implies that some of those requesting aid in dying may be reacting to depression instead of reacting rationally (Callahan 1994). Another implication is that

many people thought to be able to make decisions for themselves may not be in the best condition to do so. This implication is an important factor when the ethical code associated with the living will requires the patient to be competent when the living will is completed.

There are three guidelines to consider when defining the state of the patient's mind. The first is the need to ensure that neither the patient nor the physician is suffering from depression. Second, the patient's judgment cannot be clouded by excessive medication. Last, there should be a clear understanding of the medical situation, the life expectancy, and other alternatives (Sampaio 1992). The Ninth Circuit Federal court has upheld the right for the competent patient to decide whether he or she wishes to forego life-sustaining treatment. But the the decision did not give the physician the right to assist in euthanasia (Hammond 1996).

The Patient Self-Determination Act was passed in order for the patient to take an active role in his or her treatment. In order to allow the patient to make an informed decision, many medical organizations are relying on social workers to discuss the options with the patient and to encourage him or her to leave clear advance directives (Osman and Perlin 1994). Some social workers find that they are now in a situation requiring them to

advise the terminally ill patient on end-of-life decisions and simultaneously establish guidelines for social policy (Wesley 1996).

Education, Socioeconomic Status, and Euthanasia

The level of education and socioeconomic status are associated with the acceptance of euthanasia (Cicirelli 1997; Holden 1992; Huber et al. 1992; Kelner 1995).

> Activists [pro-euthanasia] were better educated and had more professional and managerial jobs....The most clear-cut [indicator] was that educational attainment was the key predictor of attitudes. Approval of euthanasia was positively correlated with a higher level of education. (Kelner 1995, p. 544)

Kelner's study (1995) reinforces the study by Huber et al. (1992), which found that the more education and income a person has, the more likely that he or she will be in favor of legalizing euthanasia.

Schonwetter, Walker, and Robinson (1995) state that there were fewer advance directives, such as living wills and "do not resuscitate" orders, when the subjects were non-Caucasian and had lower educational levels. Other differences in socioeconomic data were not observed in this study. The study was conducted on patients already in a Hospice program. William McDonald has found that

> lower household income is positively associated with biblical ethicalism and negatively associated with political conservatism, while education is negatively associated with biblical ethicalism. (McDonald 1998b, p. 418)

These findings indicate that socioeconomic status and political conservatism account for much of the differences found between races on the topic of euthanasia (McDonald 1998b).

Another issue is the economic ramifications connected with euthanasia. Many economists are quick to point out the positive benefits of euthanasia. Between 25 and 35 percent of Medicare expenditures go to six percent of those enrollees who will die within the year (Callahan 1987). It is suggested that acceptance of euthanasia will help contain the rising cost of health care in our country, for those over the age of 65 years account for one third of the nation's health-care expenses.

On the other hand, some have even suggested that legalized euthanasia has the possibility of being abused in what is now the business of medicine. It may provide better profit potentials for health care companies to push for euthanasia when the treatment of a curable disease is too costly for that company (Gorman and Roberts 1996). Economic considerations might force our society to ration the health-care distribution to those who will benefit from it. Costly life-prolonging treatment could possibly one day not be offered to the elderly or hopelessly ill in order to provide health-care to those it would benefit

(Yates and Glick 1997).

> Society has long been familiar with some of the issues surrounding the artificial prolongation of life, such as malpractice litigation and the excessive expense of new medical technology. (Osman and Perlin 1994, p. 245)

Medicare is an example of our society's lack of preparation in dealing with the terminally ill. Medicare was set up as a way of providing treatment at the time treatment is most needed. It was not anticipated that it would be used in treating the slowly dying (Lynn 1999).

The biggest concern in the euthanasia debate is whether a right to die means a duty to die (Fung 1993). Hardwig (1997) also believes that in some ways there is a duty to die:

> Ending my life if my duty required might still be difficult. But for me, a far greater horror would be dying all alone or stealing the future of my loved ones in order to buy a little more time for myself. I hope that if the time comes when I have a duty to die, I will recognize it, encourage my loved ones to recognize it too, and carry it out bravely. (Hardwig 1997, p. 42)

But many others are afraid that replacing medical care with euthanasia will allow for greater abuses later as it did 60 years ago in Germany.

As the controversy of euthanasia is fought in the courtrooms and in medical ethics committee meetings, the patients and their families are becoming more active. In recent years many family members of the irreversibly ill

have given up on the system to perform euthanasia. The result is an increase in "mercy killings," in which a family member takes the life of the patient.

> As the public debate continues to focus on whether the dying should have the right to request and receive aid-in-dying from physicians, the terminally ill--together with their family and friends--continue to take matters into their hands. (Jamison 1995, p. 7).

To further discuss the possible variations of attitudes concerning euthanasia among different denominations, classical theorectical perspectives dealing with Protestants are examined in the next chapter. In addition, theories by Glock and Stark are also examined in the following chapter.

CHAPTER 3

THEORY

There is a problem with trying to address euthanasia with any type of social theory because of the individualistic nature of the act. Yet it is still a social problem in that it deals with the norms and values of society and of the patient. Theories attempting to explain such an act have to address both the micro and the macro issues. This problem has been addressed by others using such theories as symbolic interactionism and rational choice. One researcher even discusses the difficulty that confronts individuals when they debate their own attitude in death with dignity

> Guidelines of how to die with dignity cannot be built on the individualism of John Locke or the humanitarian ideals of Jean Jacque Rousseau but rather on a sense of civil responsibility to oneself and to others. (Sampaio 1992, p. 433)

Active euthanasia is considered by all groups to be a type of suicide because it involves a person taking a deliberate action to end his or her own life (The Hemlock Society 1995). Suicide and the religious factors affiliated with it have been a point of interest to sociologists since the days of Emile Durkheim and Max

Weber.

The debate over euthanasia and religion is an argument concerning ethics. Often one hears the argument that having the ability to affect something does not mean that it should be affected. Perhaps the encroachment of technology on the process of dying and its ability to hinder that process serve as a micro example of Weber's "disenchantment of the world," because now the natural process of dying can suffer from "meaningless and lack of dignity" (Madan 1992, p. 426) Weber points out that religion not only affects how we view ethical issues but also how we form our attitudes about the world.

> Religious ethics penetrate into social institutions in very different ways. The decisive aspect of the religious ethic is not the intensity of its attachment to magic and ritual or the distinctive character of the religion generally, but is rather its theoretical attitude toward the world. (Weber [1922] 1964 p. 209)

But Weber argues that religion is merely a form of social control. To Weber gods of all religions are the "guardians of the legal order" (Weber [1922] 1964 p. 35), and the legal order is set forth by man or nature.

> Even when the order of nature and of the social relationships which are normally considered parallel to it, especially law, are not regarded as superordinate to the gods, but rather as their creations...it is naturally postulated that god will protect against injury the order that he has created. The intellectual implementation has far-reaching consequences for religious behavior and

> for the general attitude toward the god. It stimulated the development of religious ethic, as well as a differentiation of demands made upon man by nature, which latter so often proved to be inadequate. (Weber [1922] 1964 p. 37)

To Weber religious ethics are a tool used by man to manipulate the ideals of society. The doctrine of the religion will thus create a general attitude about ethical issues in a society. It is hypothesized that the more the religious doctrine is open to individual interpretation, the less regulated the ethics set forth in the doctrine will be.

Durkheim's study on suicide examined various aspects of suicide and their relations to social factors. In his study of egoistic suicide Durkheim examined how different religious denomination affected suicide rates. He noted a higher suicide rate in Protestant denominations than in any other religious affiliation.

> Protestants are found to kill themselves much more often than Catholics. There are even countries like Upper Palatine and Upper Bavaria, where the population is almost wholly Catholic (92 and 96 per cent) and where there are nevertheless 300 and 423 Protestant suicides to 100 Catholic Suicides. The proportion even rises to 528 per cent in Lower Bavaria where the reformed religion has not quite one follower to 100 inhabitants. (Durkheim [1897] 1975 p. 42)

Durkheim notes only one Protestant denomination as an exception to this generalization, which is the Anglican Church of England.

To Durkheim ([1897] 1975) the degree of integration of the parishioners is the one major differences between the Catholic and Anglican church and the other Protestant churches. The Catholic and Anglican churches had a higher ratio of clergy to parishioners at the time of this study. These two churches also had doctrines that are far stricter than the doctrines of the other Protestant denominations. The Protestant denominations allowed more investigation into the doctrines than do the Catholic and Anglican churches.

> A whole hierarchical system is devised, with marvelous ingenuity, to render tradition invariable. All variation is abhorrent to Catholic thought. The Protestant is far more the author of his [sic] faith. The bible is put in his [sic] hands and no interpretation is imposed upon him [sic]. The very structure of the reformed cult stresses this state of religious individualism. Nowhere but in England is the Protestant clergy a hierarchy; like the worshippers, the priest has no other source but himself and his conscience. (Durkheim [1897] 1975 p. 45)

Durkheim also says that the strict Catholic and Anglican doctrines enable their worshippers to be fully socialized in the belief system, whereas the free interpretation allowed by the Protestant denominations do not fully socialize the worshippers with the law set forth in the doctrines. Thus, Durkheim argues that the more integrated a person is into religion, the more conservative his or her beliefs will be in matters of religion (Durkheim

[1897] 1975).

In *The Elementary Forms of Religious Life*, Durkheim mentions that in some primitive religions a person's soul is closely linked to that person's body. When the body is tired or ill, so is its soul. According to Durkheim, in some primitive religions that believed in the connection between body and soul, kings and wise men were not allowed to advance to a state of senility or injury that might harm the soul. They were put to death in order to maintain the sanctity and nobility of their souls (Durkheim [1915] 1965). Thus, certain primitive religions practiced active euthanasia.

This primitive concept of the soul would suggest that in a society such as ours, in which the concept of soul takes on a duality of mind and body, euthanasia would be seen as a way to move on into the afterlife. Instead, the Christian religion teaches that life is a gift from God (Kelner 1995). It is, therefore, the belief of the researcher that individual autonomy within religion and religiosity are going to be the determining factors of how acceptable euthanasia is to some people.

However, not all religions share the same belief. Glock and Stark (1965) document differing denominational interpretations of religious doctrines and beliefs. Some of the differences that they found included the belief in

the divinity of Jesus, the belief in the virgin birth of Jesus, the belief of life after death, and the belief of the existence of the devil.

Glock and Stark (1965) used the results of their study to classify the Protestant denominations based on the degree of liberal interpretation in each denomination. The classifications were the liberals (Congregationalists, Methodists, and Episcopalians), the moderates (Presbyterians and the Disciples of Christ), the conservatives (Lutherans and the American Baptist), and the fundamentalists (Missouri Synod Lutherans, Southern Baptists, and many smaller sects) (Glock and Stark 1965). This study demonstrated how attitudes and ideals of the parishioners vary according to their denomination.

Research shows that people with strong religious beliefs are going to be less likely to favor passive or active euthanasia than people with secular concerns (Carter 1993; Hemlock Society 1995; Holden 1992). It would then be reasonable to hypothesize that as Protestant denominations are trying to align with secular consciousness (Berger 1969), they become more tolerant of secular beliefs. It is, therefore, possible that some Protestant denominations will favor euthanasia more than others do, depending on how liberal the denomination is.

Both of the arguments set forth by Durkheim and Glock and Stark are consistent with the findings of Hertel and Hughes (1987) in a study of denomination and religiosity determining the political and moral values of the worshipper. The results of this study showed that higher religiosity was associated with conservative moral standards within the denomination and that the denomination's views on family matters were consistent with the categories set up by Glock and Stark (1965). The findings of the Hertel and Hughes (1987) study also indicate that religiosity is negatively related to acceptance of abortion. Holden (1992) states in his research that acceptance of abortion is a predictor of the acceptance of euthanasia. It is, therefore, hypothesized by the researcher that the differences in the interpretation of the scripture by different denominations and the religiosity of the parishioner can be used as predictors of the acceptance of euthanasia. Thus, as religion and self perceptions are linked together, these two concepts can be used as a predictor of the likelihood of the individual accepting euthanasia as an alternative to artificially prolonged life (Vernon 1962).

The sociological data on religion provided above suggest that religiosity and denominational affiliation are strong influences on the individual's views on ethical

issues such as euthanasia. Thus, it becomes necessary to examine the religious denomination of an individual in order to evaluate that person's view on topics that have religious implications, such as euthanasia. In order to understand the differences in the Protestant views of euthanasia

> the social context within which a person engages in religious experiences must be examined before it is possible to assess the meaning of his [sic] act or assess his [sic] individual motivation. (Glock and Stark 1965, p. 168)

In summary, Weber's formation of religious ethics, Durkheim's idea of socialization and religious integration, and Glock and Stark's value categorization of Protestant denominations were all considered when examining the differences that the researcher hypothesized are present in the acceptance or rejection of both passive and active euthanasia. Only with the basic understanding of these concepts could the researcher get a clear understanding of belief patterns and ideals of the different Protestant denominations concerning end-of-life issues.

The use of these concepts enabled the researcher to distinguish not only differences between denominations but also differences within denominations based on religiosity. The researcher believed that euthanasia might be more acceptable to Protestants based on belief

patterns recorded in a study by Donahue (1993). One third of the Protestants sampled indicated that they believe "all spiritual truth and wisdom is within" (Donahue 1993, p. 182). This finding supports Durkheims concept of the more liberal interpretation of religious doctrines among the Protestant denominations and, therefore, may possibly also indicate liberal views as predicted by Glock and Stark (1965).

Hypotheses

On the basis of the previous research and the social theories by Durkheim, Weber, Glock, and Stark, six hypotheses about euthanasia were derived:

H_1: There will be a significant difference in the attitudes toward euthanasia among the various denominations.
H_2: Conservative political beliefs will be negatively correlated to pro-euthanasia attitudes.
H_3: Religiosity will be negatively correlated with pro-euthanasia attitudes.
H_4: Socioeconomic status will be positively correlated with pro-euthanasia attitudes.
H_5: Higher education levels will be positively correlated with pro-euthanasia attitudes.
H_6: Having had experience with a dying friend or relative will be positively correlated with pro-euthanasia attitudes.

The various religious denominations were put into two groups ("Episcopalians" and "other") and examined to see if the Episcopalians were more likely to favor euthanasia than other denominations. This hypothesis is based on the previous work of Glock and Stark (1965). It

was expected that conservative political beliefs would be negatively correlated to pro-euthanasia attitudes. This hypothesis was based on previous research (Adams et al. 1978; Gorman and Roberts 1996; Holden 1992; Jordan 1994). It was also believed that a higher level of religiosity would be a predictor of anti-euthanasia attitudes. This hypothesis was based on the findings of a previous study (Hertel and Hughes 1987) concerning religious denominations, religiosity, and abortion. It was retested in this study examining active and passive euthanasia.

It was believed that there would be a positive correlation between socioeconomic status and euthanasia attitudes. There is a noted difference associated with various denominations and the average socioeconomic level of the members of different denominations (Tamney, Burton, and Johnson 1988). The researcher tested socioeconomic status in order to evaluate differences within the same denomination.

Another hypothesis was that higher education within each denomination could be used as a predictor of the acceptance of euthanasia. This assumption was based on Holden's (1992) research in which he found that higher education was positively correlated to pro-euthanasia attitudes.

The last hypothesis was that there would be a positive correlation between pro-euthanasia sentiment and experience with a dying friend or relative. This belief was based on past research (Hemlock Society 1995; Quill 1994).

The following chapter describes the methods by which these hypotheses were tested. Detailed information on the survey population is included in Chapter 4.

CHAPTER 4

METHODS

A survey, designed by the researcher, was used to obtain the information for this project. The sample size of this study was 134 adults from four local Protestant Churches within a two-mile radius of each other in a mid-sized city in Kentucky. Each church chosen for study was a different Protestant denomination representing varying degrees of conservativeness as established by Glock and Stark (1965). The researcher obtained verbal and written permission from the clergy of each church to administer surveys to their congregations.

The first section of the questionnaire asked the respondent to rate, on a ten-point Likert scale, ten medical actions that would end a person's life. The scale was coded so that a lower score indicated that the respondent believed that the action was passive (i. e., "allowed the person to die") and higher scores indicated that the action was believed to be active (i. e., "directly caused death"). See Appendix A.

The next section of the survey required the

respondents to answer whether they believed the actions would be appropriate based on six vignettes. The vignettes were made up of three different medical conditions, described once as an unknown patient and once as a relative of the respondent. At the end of each vignette the ten actions were listed and the respondents were asked to circle "yes" or "no" based on their beliefs about whether a doctor should be allowed to take these actions at the patient's request. These vignettes were not used in the final analysis because no significant variations were found in the sample population.

The last section on the survey asked questions regarding the legal and ethical beliefs concerning types of euthanasia. The last section was designed to collect the demographic data needed to complete the research.

Dependent Variable

The dependent variable was the attitude concerning euthanasia: pro-euthanasia or anti-euthanasia. Six forced choice questions were used to evaluate the respondents' attitudes about euthanasia (see Table 1). The questionnaire did not provide any opportunity to answer "undecided." It was the belief of the researcher that everyone has an opinion about euthanasia. By not providing an "undecided" option it was hoped that more of the participants would answer with their true feelings.

Table 1. Overall Frequency of the Responses to the Dependent Variable Questions

	Yes	No
Do you believe that physician-assisted suicide should be legalized?	34.6%	65.4%
Do you believe that physician-assisted suicide is ethical?	35.2%	65.8%
Do you believe that a patient with a terminal illness has the right to forego life sustaining treatment?	98.5%	1.5%
Do you believe that a patient with a terminal illness has the right to end his or her life to avoid suffering?	61.4%	38.6%
Do you believe that a patient with a terminal illness has the right to end his or her life to avoid an undignified death?	59.1%	40.9%
Do you believe that a patient with a terminal illness has the right to receive aid in dying?	55.8%	44.2%

Independent Variables

The survey was comprised of a series of questions designed to examine the importance of six independent variables with regard to the participants' attitudes concerning euthanasia. The variables were religious denomination, political conservatism, religiosity, socioeconomic status, educational level, and individual experience with a dying friend or relative.

Religious beliefs were examined to determine whether religious denomination could be used to predict attitudes

concerning euthanasia. It has been noted that there are differences in the acceptance of euthanasia among different denominations. It was expected that liberal Protestant denominations would be more open to the use of euthanasia for the irreversibly ill than would a more conservative Protestant denomination. The denominational affiliation of the respondent was self-reported on the questionnaire (see Table 2).

Table 2. Denominations Represented in Sample

	Frequency	Valid Percent
Methodist	6	4.5
Lutheran	10	7.5
Episcopalian	67	50.4
Baptist	8	6
Presbyterian	12	9
Disciples of Christ	27	20.3
Other	3	2.3
Missing	1	
Total	134	100

This survey also requested that the respondents rate their political views. Half of the respondents (50%) rated themselves as moderate. The remaining half rated themselves as conservative (31.8%) or liberal (18.2%). Over 98 percent of the sample indicated that a terminal patient has the right to forego treatment.

Religiosity would measure the involvement one has in one's church. It was believed that the higher the

religious involvement, the more conservative the attitude of the parishioner. Religiosity was self-reported by the respondent on the questionnaire (see Table 3).

Table 3. Self-Rated Religiosity

	Frequency	Valid Percent
Slightly religious	2	1.5
Moderately religious	59	44.4
Highly religious	72	54.1
Missing	1	
Total	134	100

Research also reveals that there seems to be a positive correlation between higher educational levels and pro-euthanasia attitudes (Hemlock Society 1995; Holden 1992). The existing research does not deal with education levels and pro-euthanasia attitudes among different religious denominations. Number of years of education was self-reported by the respondent on the questionnaire.

Individual experience with a dying friend or relative was the most personal independent variable to be tested in this research. It deals with the participants' past experience with people they knew who were the victims of an agonizing death. To measure the respondents experience, two questions were asked concerning whether he or she had experience with a dying friend or relative. These variables were examined to determine the effect they had on

attitudes concerning euthanasia among those who are not dying but still have witnessed the death of another person.

Demographics

The sample contained 57 males (42.5%) and 77 females (57.7%). The respondents' ages ranged from 18 to 85, with the average age just under 54 (53.94). The older sample was expected because the sample frame was denominations that traditionally attract older members. The majority of the respondents (83.6%) were currently married (see Table 4), and 88.1 percent had children (see Table 5).

Table 4. Marital Status of Respondents

	Frequency	Percent
Married	112	83.6
Divorced	5	3.7
Separated	1	0.7
Widowed	7	5.2
Single	9	6.7
Total	*134*	*100*

Table 5. Number of Respondents Having Children

	Frequency	Percent
Yes	118	88.1
No	16	11.9
Total	*134*	*100*

The sample rated extremely high in household family income, with 72.7 percent earning $50,000 or more a year (See Table 6). The majority of the sample (73.1%) had

earned at least a baccalaureate degree (see Table 7). These percentages are understandable when it is considered that persons with higher levels of education and higher socioeconomic status are more likely to answer questionnaires.

Three quarters of the sample has had experience with a dying relative (76.7%). Also, three quarters of the sample has had experience with a dying friend (75%). People who had had experience with either a dying relative or a dying friend constituted 86.3 percent of the sample. This survey allowed the respondents to rate their own religiosity. Over half of the respondents (54.1%) rated themselves as "highly religious" (see Table 3).

Analysis Plan

To test these hypotheses the researcher used data reduction to examine whether the subjects differentiated between passive and active euthanasia on their own and logistic regression to see which variables were associated with end-of-life beliefs. The data reduction method loaded all the Likert scale variables into two components (passive and active euthanasia).

Table 6. Gross Annual Income of Respondents

	Frequency	Valid Percent
Less than $10,000	4	3.3
$10,000 - $19,999	5	4.1
$20,000 - $29,999	5	4.1
$30,000 - $39,999	7	5.8
$40,000 - $49,999	12	9.9
$50,000 - $59,999	23	19
$60,000 - $69,999	12	9.9
$70,000 - $79,999	12	9.9
$80,000 or more	41	33.9
Missing	13	
Total	134	100

Table 7. Education Completed by Respondents

	Frequency	Percent
Less than high school	1	0.7
High School	9	6.7
Some college/ vocational training	26	19.7
College	38	28.4
Graduate or professional	60	44.8
Total	134	100

The Episcopalians represented 50 percent of the sample population. Because of the large size of the Episcopalian sample (see Table 2) the researcher decided to divide the denomination variable into two categories (1 = Episcopal, 0 = others).

The above variable was then put into a logistic regression formula with eleven other variables: being married (1 = married, 0 = others), having children (1 = children, 0 = no children), sex (1 = male, 0 = female), political views, religiosity, church attendance, annual

household income, education obtained, age, having experienced a friend die, and having experienced a relative die. Logistic regression was used to determine how these covariates interacted with each other on the subjects' responses to the questions concerning legalizing physician-assisted suicide, the ethics of physician-assisted suicide, avoiding an undignified death, avoiding suffering, and the right to receive aid in dying.

The following chapter details the results of the above questions. Demographic data was included in the logistic regression models to detect variations.

CHAPTER 5

RESULTS

This study was conducted to detect variations in attitude among Protestant denominations on the topic of euthanasia. In several instances variation was found among other factors.

The first question on the survey was designed for the respondents to rate ten different actions according to whether they believed the action to be directly causing death or allowing death to occur. The ten variables were calculated into a factor analysis using the Oblimin Rotation Method, which yielded two non-correlated factors. Because the factors were uncorrelated, varimax rotation was used.

All variables were loaded into two components (see Table 8). Component 1 loaded six variables traditionally associated with passive euthanasia in the medical community (Eigenvalue 3.926). Component 2 contained the four variables associated with active euthanasia (Eigenvalue 3.309). These two components accounted for 72.345 percent of the variance (see Figure 1). The factor analysis was

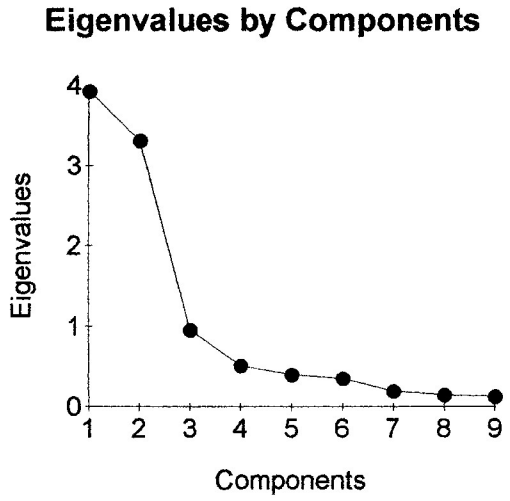
used to insure that the survey sample were observing the the same actions as active or passive euthanasia.

A reliability analysis was executed to test the variables in the components. The variables in Component 1 (Alpha = .8669) and Component 2 (Alpha = .9265) proved reliable.

Table 8. Factor Loadings

Component 1 (passive euthanasia)	Component 2 (active euthanasia)
Disconnecting feeding tube	Hooking patient to a suicide machine
Disconnecting respirator	Providing patient with suicide pills
Not starting treatment	Giving the patient a lethal injection
Stopping treatment	Giving the patient lethal doses of opiates
Honoring a DNR order	
Withholding surgery	

Figure 1.



Logistic Regression Data

There was notable variation in the logistic

regressions run on the data that this study yielded. The question concerning the right of the patient to end his or her life to avoid an undignified death yielded four significant covariates (see Table 9). Episcopalians were three times as likely to answer that a person had that

Table 9. Logistic Regression of the Sample Indicating That the Patient Has the Right to Die with Dignity

	B	S. E.	R	Odds Ratio
Having a relative die	.689	.6383	.0000	1.9917
Having a friend die	-1.5985*	.7337	-.1376	.2022
Being Episcopalian	1.141*	.5022	.1477	3.1299
Being less politically conservative	.9806*	.3834	.1770	2.6661
Being male	-.0559	.505	.0000	.9457
Having children	-1.4851	1.2752	.0000	.2265
Being married	.0554	1.2014	.0000	1.057
Attending church	.1633	.3879	.0000	1.1774
Being religious	-.9657	.5099	-.1046	.3807
Being older	.014	.0207	.0000	1.0141
Having more education	.7532*	.3054	.1679	2.1238
Having a higher income	.0626	.1153	.0000	1.0646
Constant	*-1.2851*	*2.3224*		

* ($p < .05$)

right. This covariate supports the first hypothesis concerning the variation of attitudes toward euthanasia among Protestant denominations. Persons with higher

levels of education were more likely to answer that the patient had that right. This finding supports the hypothesis that higher levels of education are positively correlated to positive euthanasia attitudes. Persons of less conservative political views were more likely to answer that the patient had that right, thus supporting the hypothesis that political conservativism is negatively correlated to positive euthanasia attitudes. This variable was the most important in this model.

Perhaps the most surprising finding concerned experience with previous deaths. Respondents who did not see a friend die were almost five times more likely to say that the patient did not have that right than were those who did see a friend die. This finding did not support the predicted hypothesis concerning having a friend who died and positive correlation with euthanasia attitudes.

The next question to be analyzed had to with the right of a patient to avoid suffering. The results from the question concerning the right of the patient to end his or her life to avoid suffering yielded two covariates at the .05 level (see Table 10). An Episcopalian from the sample was over three and a half times more likely to answer that the patient had that right than were the members of other denominations in the sample. This finding

further supports the hypothesis that there are variations within the Protestant denominations concerning euthanasia. Higher levels of education made the respondent more likely to answer that the patient had that right. This variable was the most important in this model. This finding supports the hypothesis concerning the positive correlation between education and positive euthanasia attitudes.

TABLE 10. Logistic Regression of the Sample Indicating That the Patient Has the Right to Avoid Suffering

	B	S. E.	R	Odds Ratio
Having a relative die	.2944	.6251	.0000	1.3423
Having a friend die	-1.4403	.742	-.1114	.2368
Being Episcopalian	1.3065*	.5102	.1789	3.6933
Being less politically conservative	.7128	.3683	.1107	2.0398
Being male	-.193	.5067	.0000	.8245
Having children	-1.7543	1.3599	.0000	.173
Being married	-.0844	1.0858	.0000	.9191
Attending church	.3707	.3903	.0000	1.4481
Being religious	-.9686	.5096	-.1064	.3796
Being older	.0018	.0206	.0000	1.0018
Having more education	.9203**	.3212	.2088	2.5099
Having a higher income	-.0270	.1191	.0000	.9733
Constant	*-.1555*	*2.3639*		

* ($p < .05$) **($p < .01$)

The next question to be analyzed was controversial to some of the respondents. Often the respondents made notes on the survey inquiring if aid in dying meant hospice care. Responses to the question of whether a terminally ill patient had the right to receive aid in dying provided three significant covariates (See Table 11). The less

TABLE 11. Logistic Regression of the Sample Indicating That the Patient Has the Right to Aid-in-Dying

	B	S. E.	R	Odds Ratio
Having a relative die	-.3735	.6137	0000	.6883
Having a friend die	.0717	.6674	.0000	1.0743
Being Episcopalian	.1660	.4744	.0000	1.1806
Being less politically conservative	.9827*	.3571	.1915	2.6716
Being male	-.1982	.4782	.0000	.8202
Having children	-.7822	.9385	.0000	.4574
Being married	.9234	.9281	.0000	2.5179
Attending church	-.1023	.3676	.0000	.9027
Being religious	-1.0259*	.4733	-.1333	.3585
Being older	-.0174	.0186	.0000	.9828
Having more education	.6541*	.2785	.1522	1.9234
Having a higher income	-.0457	.1103	.0000	.9553
Constant	*1.0165*	*2.1668*		

* ($p < .05$)

politically conservative respondents were more likely to

agree that the patient possessed that right. This variable was the most important in this regression model. This finding offers more support for the hypothesis concerning political conservatism. Higher levels of education made the respondent more likely to indicate the belief that the patient had that right. This relationship gives further support to the hypothesis on education. Respondents with weaker religious beliefs were more likely to indicate that the patient did not have that right than those who have stronger religious beliefs. This finding supports the hypothesis concerning the inverse relationship between religiosity and positive attitudes concerning euthanasia.

The question in which the respondent determined whether physician-assisted suicide is ethical produced three significant covariates (see Table 12). Those respondents with higher levels of education were more likely than the rest of the sample to indicate that it is ethical. Respondents who are less politically conservative were more likely to indicate that it is ethical.

Those respondents without strong religious beliefs were more likely to answer that physician-assisted suicide is ethical than were those with strong religious convictions. For this logistic regression model religiousity was the most important variable. These covariates give further support to previously mentioned

hypotheses.

TABLE 12. Logistic Regression of the Sample Indicating That Respondents Believe Physician-Assisted Suicide is Ethical

	B	S. E.	R	Odds Ratio
Having a relative die	.4584	.6480	.0000	1.5816
Having a friend die	.9569	.7205	.0000	2.6035
Being Episcopalian	.6336	.5028	.0000	1.8843
Being less politically conservative	.8442*	.3691	.1512	2.3262
Being male	.4159	.5077	.0000	1.5158
Having children	-1.0502	1.0397	.0000	.3499
Being married	.8517	1.0231	.0000	2.3437
Attending church	.4763	.3991	.0000	1.6101
Being religious	-1.3103*	.5321	-.1696	.2697
Being older	-.0061	.0194	.0000	.994
Having more education	.7378*	.3296	.1460	2.0914
Having a higher income	-.0139	.1156	.0000	.9862
Constant	*-3.1930*	*2.3338*		

* ($p < .05$)

The question of whether physician-assisted suicide should be made legal produced five covariates (see Table 13). Respondents who had experienced the death of a friend were almost five times more likely to answer that it should be legalized. The relationship between having a friend who suffered a terminal illness and the favoring of legalizing

physician-assisted suicide supports the hypothesis concerning positive attitudes about euthanasia among those who have lost a friend. Less politically conservative respondents were more likely to answer that it should be legalized. The married respondents were over nine times as likely to answer that it should be legalized. This variable was the most important one in this model.

TABLE 13. Logistic Regression of Respondents Favoring Legalizing Physician-Assisted Suicide

	B	S. E.	R	Odds Ratio
Having a relative die	-.3104	.6591	.0000	.7332
Having a friend die	1.5913*	.7522	.1316	4.9101
Being Episcopalian	.7807	.5242	.0390	2.1829
Being less politically conservative	1.3223*	.4210	.2344	3.7520
Being male	.8753	.5301	.0713	2.3997
Having children	-2.6868*	1.1353	-.1587	.0681
Being married	2.2475*	1.1196	.1191	9.4637
Attending church	.0784	.4084	.0000	1.0815
Being religious	-1.1668*	.5381	-.1374	.3114
Being older	-.0193	.0194	.0000	.9809
Having more education	.5126	.3149	.0674	1.6696
Having a higher income	-.1066	.1165	.0000	.8989
Constant	*-1.2992*	*2.2229*		

* ($p < .05$)

The respondents without children were fourteen and a half times more likely to answer that it should be legalized than were those who have children. These findings were not expected. The respondents without strong religious beliefs were three times more likely to answer that it should be legalized than were those with strong religious beliefs. This association strengthens the hypothesis concerning the inverse relationship between religiosity and euthanasia attitudes.

CHAPTER 6

DISCUSSION AND CONCLUSIONS

The researcher's first hypothesis concerning the variation in attitudes among Protestant denominations was supported by the logistic regressions using the right to end one's life with dignity and the right to end one's life to avoid suffering. The Episcopalians in the research proved to be more likely to support these aspects of euthanasia than the other denominations.

The researcher believes that this attitude stems from two factors. As noted in Chapter 2, the Episcopal Church has been documented as being more open in the interpretation of their doctrines. This attitude permits Episcopalians to examine ideas on topics such as euthanasia and judge those topics using his or her own opinion. Church doctrines are guidelines rather than a rule book.

The second reason for the more liberal attitude of the Episcopalians is the wording of the questions. The questions did not specify active or passive euthanasia, nor did it ask questions about legal or ethical beliefs. The questions asked the respondents if the patient has the

right. In a denomination where individual interpretation is an integral part of religious practices, it is expected that the respondents would want to protect the rights of the individual. It is, therefore, also understandable why no significant difference was found among the denominations on the question of legalizing physician-assisted suicide. Legalization often implies a loss of individual control, which is not desirable for free thinkers.

The second hypothesis, which stated that conservative political beliefs will be negatively correlated to pro-euthanasia attitudes, was supported in statistical analysis. This variable was significant in four out of the five logistic regressions executed for this experiment. The one regression in which it failed to be significant had the right to end life to avoid suffering as the dependent variable. On this test the significance was .0529.

The next hypothesis was that religiosity would be negatively correlated with pro-euthanasia attitudes. the hypothesis was supported by the logistic regression executed on the "right to have aid-in-dying" and the "legalizing euthanasia" questions. Religiosity was self-rated in this experiment. The higher the respondent rated his or her religiosity, the more likely he or she was to oppose euthanasia. These two questions both indicated

that the patient would be practicing active euthanasia, which seems to be reprehensible to those who judge themselves to be highly religious.

The hypothesis concerning the correlation between socioeconomic status and pro-euthanasia attitudes could not be accurately tested in this experiment due to the skewed nature of the sample on the income scale. There was too little variation in the socioeconomic status of the respondents to draw any adequate conclusions.

The hypothesis of having had experience with a dying friend or relative had varying results. At no time was the association between having a relative die with a terminal illness and pro-euthanasia attitudes significant. Having known a friend who died of a terminal illness proved significant in two of the models. In one test the results conflict with the hypothesis, and in the other test it supports the hypothesis. The question on which the response went against expectations concerned the right of the patient to end his or her life to avoid an undignified death. The question on which the response supported the hypothesis concerned legalizing physician-assisted suicide. The researcher believes that the experience of a friend, particularly of the same age, has greater influence than the death of some relatives. It is also believed that

respondents feel that while having a friend die may make the respondent more likely to answer that physician-assisted suicide should be legalized, avoiding an undignified death is not a basis on which this action is acceptable.

The final hypothesis of this study was that higher levels of education are positively correlated with pro-euthanasia attitudes. This variable was repeatedly found during the logistic regression executions. The researcher believes that this variation occurs because of the diverse experiences of those who possess more education. These experiences include new ideas learned in academic settings and opportunities to experience diversity in the workplace made possible by higher education. The exposure to new ideas allows people to be more open-minded about controversial topics such as euthanasia.

The factor analysis indicated that the sample population distinguished between types of active and passive euthanasia without any instruction. The researcher believes this information serves as a control in that the sample population was defining the actions based on the facts and not on religious beliefs.

Conclusions

The findings in this study support the theory of variation among Protestant denominations as set forth by

Glock and Stark (1965). Glock and Stark noted differences in conservativism on many social issues among the Protestant denominations. Likewise, the results of this study show variation among Protestant denominations on the social issue of euthanasia. It provides evidence that the variation among denominations is significant enough that inclusive statements about the beliefs of the Protestant denominations on end-of-life issues are inadequate

The major problem with this project was the low response rate from the various congregations. The highest response rates were from the Disciples of Christ congregation (85%) and the Episcopalian congregation (57%). Other congregations in the study had a return rate of less than ten percent each. The researcher believes that the irregular response rates were due to variation in the collection methods. Each congregation was approached by the minister in a different manner. Most of the time the researcher had little control over how the ministers addressed the topic of the survey. The best response rate was achieved by the researcher when he accompanied the minister to Sunday School classes and addressed the people there. However, this method also jeopardized the use of church-related activities as a measure of religiosity because people attending Sunday School are somewhat more

involved in church activities than are those who attend church services only. The researcher had to rely on variations of self-rated religiosity among Sunday School class attendees.

The researcher has a theory relating to the significance of being married and having children on the topic of favoring the legalization of physician-assisted suicide. The information suggests that those with children seem to be less likely to want to give up on the possibility of a miracle cure. The researcher believes that this is reluctance to give up is based on a feeling of parental obligation to the children to be there for them. This information also suggests that being married increases the likelihood of favoring the legalization of physician-assisted suicide, possibly based on a desire not to avoid seeing the marriage partner suffer needlessly. These conflicting responses should be a topic for further research. Enough information on family relations and euthanasia was not examined to formulate an adequate theory on this finding.

Further research on the different beliefs among Protestant denominations should focus on only two, one conservative and one liberal. The researcher believes that further variation in beliefs can be found if the size of the sample is increased. However, the purpose of this

project was to show that it is not sufficient to combine all Protestant denominations into one category when discussing social issues. This idea was supported by separating the Episcopalians from the rest of the Protestant sample. This study has shown variation concerning the beliefs about euthanasia among these Protestant denominations. Further studies of variations among the Protestant denominations on other social issues should still be undertaken.

This research project had several limitations. No racial minorities were represented in the sample. Nor was there much variation in socioeconomic status. These limitations can be avoided in the future through selecting a research population in a less affluent area. The research results can not be generalized to the population. The sample population was generally better educated and represented fewer occupational categories than would typical church congregations.

APPENDICES

APPENDIX A

QUESTIONNAIRE

1. Over the last decade there have been a number of cases in which patients have asked a doctor to help them end their lives. Listed below are several ways in which a doctor could help patients end their lives. Some people hold that in some of these actions the doctor takes a more active role than in others. Please rate the following acts in terms of how direct a role you believe the doctors play in ending the patients life from
"NOT ACTIVE AT ALL" (1) to "DIRECTLY CAUSING DEATH TO OCCUR" (10).

	Not Active at All									Directly Causing Death to Occur
Disconnecting a feeding tube	1	2	3	4	5	6	7	8	9	10
Disconnecting a respirator	1	2	3	4	5	6	7	8	9	10
Hooking the patient to a machine which will allow the patient to end his/ her life	1	2	3	4	5	6	7	8	9	10
Providing patient with suicide pills	1	2	3	4	5	6	7	8	9	10
Not starting treatment	1	2	3	4	5	6	7	8	9	10
Stopping treatment	1	2	3	4	5	6	7	8	9	10
Honoring a "do not resuscitate" order	1	2	3	4	5	6	7	8	9	10
Giving the patient a lethal injection	1	2	3	4	5	6	7	8	9	10
Withholding surgery that could keep the patient alive but in a diminished state	1	2	3	4	5	6	7	8	9	10
Giving the patient lethal doses of opiates (morphine)	1	2	3	4	5	6	7	8	9	10

2. A patient whom **YOU DO NOT KNOW** was involved in an automobile accident. This patient suffered brain damage and is in a coma. Doctors believe that this patient will not recover, and can only survive through the use of a life support system. Before the accident, the patient prepared a living will, which indicated a desire not to be kept alive through artificial means. Indicate whether the physician should be allowed to take the following actions.

Disconnecting a feeding tube	**YES**	**NO**
Disconnecting a respirator	**YES**	**NO**
Hooking the patient to a machine which will allow the patient to end his/her life	**YES**	**NO**
Providing the patient with suicide pills	**YES**	**NO**
Not starting life-sustaining treatment	**YES**	**NO**
Stopping life-sustaining treatment	**YES**	**NO**
Honoring a "do not resuscitate" order	**YES**	**NO**
Giving the patient a lethal injection	**YES**	**NO**
Not performing surgery that could keep the patient alive but in a diminished state	**YES**	**NO**
Giving the patient lethal doses of opiates (morphine)	**YES**	**NO**

3. A patient **WHO IS RELATED TO YOU** has been diagnosed with an HIV infection believed to have been transmitted sexually from the patient's partner. The patient indicates to the doctor that dealing with this disease is not desirable to the patient. The patient indicates to the doctor a desire to die with dignity. Indicate whether the physician should be allowed to take the following actions.

Disconnecting a feeding tube	**YES**	**NO**
Disconnecting a respirator	**YES**	**NO**
Hooking the patient to a machine which will allow the patient to end his/her life	**YES**	**NO**
Providing the patient with suicide pills	**YES**	**NO**
Not starting life-sustaining treatment	**YES**	**NO**
Stopping life-sustaining treatment	**YES**	**NO**
Honoring a "do not resuscitate" order	**YES**	**NO**
Giving the patient a lethal injection	**YES**	**NO**
Not performing surgery that could keep the patient alive but in a diminished	**YES**	**NO**
Giving the patient lethal doses of opiates (morphine)	**YES**	**NO**

4. A patient **WHO IS RELATED TO YOU** has been diagnosed with advanced bone cancer. The patient's life may be prolonged through chemotherapy, but the cancer is terminal. The patient is expected to be in excruciating pain in the final months of life. The patient indicates to the doctor a desire to die with dignity. Indicate whether the physician should be allowed to take the following actions.

Disconnecting a feeding tube	**YES**	**NO**
Disconnecting a respirator	**YES**	**NO**
Hooking the patient to a machine which will allow the patient to end his/her life	**YES**	**NO**
Providing the patient with suicide pills	**YES**	**NO**
Not starting life-sustaining treatment	**YES**	**NO**
Stopping life-sustaining treatment	**YES**	**NO**
Honoring a "do not resuscitate" order	**YES**	**NO**
Giving the patient a lethal injection	**YES**	**NO**
Not performing surgery that could keep the patient alive but in a diminished	**YES**	**NO**
Giving the patient lethal doses of opiates (morphine)	**YES**	**NO**

5. A patient whom **YOU DO NOT KNOW** has been diagnosed with an HIV infection believed to have been transmitted sexually from the patient's partner. The patient indicates to the doctor that dealing with this disease is not desirable to the patient. The patient indicates to the doctor a desire to die with dignity. Indicate whether the physician should be allowed to take the following actions.

Disconnecting a feeding tube	**YES**	**NO**
Disconnecting a respirator	**YES**	**NO**
Hooking the patient to a machine which will allow the patient to end his/her life	**YES**	**NO**
Providing the patient with suicide pills	**YES**	**NO**
Not starting life-sustaining treatment	**YES**	**NO**
Stopping life-sustaining treatment	**YES**	**NO**
Honoring a "do not resuscitate" order	**YES**	**NO**
Giving the patient a lethal injection	**YES**	**NO**
Not performing surgery that could keep the patient alive but in a diminished	**YES**	**NO**
Giving the patient lethal doses of opiates (morphine)	**YES**	**NO**

6. A patient whom **YOU DO NOT KNOW** has been diagnosed with advanced bone cancer. The patient's life may be prolonged through chemotherapy, but the cancer is terminal. The patient is expected to be in excruciating pain in the final months of life. The patient indicates to the doctor a desire to die with dignity. Indicate whether the physician should be allowed to take the following actions.

Disconnecting a feeding tube	**YES**	**NO**
Disconnecting a respirator	**YES**	**NO**
Hooking the patient to a machine which will allow the patient to end his/her life	**YES**	**NO**
Providing the patient with suicide pills	**YES**	**NO**
Not starting life-sustaining treatment	**YES**	**NO**
Stopping life-sustaining treatment	**YES**	**NO**
Honoring a "do not resuscitate" order	**YES**	**NO**
Giving the patient a lethal injection	**YES**	**NO**
Not performing surgery that could keep the patient alive but in a diminished	**YES**	**NO**
Giving the patient lethal doses of opiates (morphine)	**YES**	**NO**

7. A patient **WHO IS RELATED TO YOU** was involved in an automobile accident. This patient suffered brain damage and is in a coma. Doctors believe that this patient will not recover, and can only survive through the use of a life support system. Before the accident, the patient prepared a living will, which indicated a desire not to be kept alive through artificial means. Indicate whether the physician should be allowed to take the following actions.

Disconnecting a feeding tube	**YES**	**NO**
Disconnecting a respirator	**YES**	**NO**
Hooking the patient to a machine which will allow the patient to end his/her life	**YES**	**NO**
Providing the patient with suicide pills	**YES**	**NO**
Not starting life-sustaining treatment	**YES**	**NO**
Stopping life-sustaining treatment	**YES**	**NO**
Honoring a "do not resuscitate" order	**YES**	**NO**
Giving the patient a lethal injection	**YES**	**NO**
Not performing surgery that could keep the patient alive but in a diminished	**YES**	**NO**
Giving the patient lethal doses of opiates (morphine)	**YES**	**NO**

8. Do you believe that physician-assisted suicide should be legalized?

YES NO

9. Do you believe that the act of physician-assisted suicide is ethical?

YES NO

10. Have you ever had experience with a relative suffering from a terminal illness?

YES NO

11. Have you ever had experience with a friend suffering from a terminal illness?

YES NO

12. Do you believe that a patient who is diagnosed with a terminal illness has the right to forego life sustaining treatment?

YES NO

13. Do you believe that a patient who is diagnosed with a terminal illness has the right to end his or her life to avoid suffering?

YES NO

14. Do you believe that a patient who is diagnosed with a terminal illness has the right to end his or her life to avoid an undignified death?

YES NO

15. Do you believe that a patient who is diagnosed with a terminal illness has the right to receive aid in dying?

YES NO

16. What was your age at your last birthday? _____

17. What is your sex? _____ male
_____ female

18. What is the highest level of education you have completed?

_____ Less than high school
_____ High school
_____ Some college or vocational
_____ College
_____ Graduate or professional

19. What is your religious denomination?

_____ Methodist
_____ Lutheran
_____ Episcopal
_____ Baptist
_____ Presbyterian
_____ Other

20. Including church attendance, how many religious activities (i.e. Bible Study Groups, Youth Fellowship Groups, etc.) do you participate in during the average week?

_____ Church services occasionally
_____ Church services only
_____ 2 - 3 church activities
_____ more than 3

21. How would you rate your religious beliefs?

_____ I am not religious
_____ I am slightly religious
_____ I am moderately religious
_____ I am highly religious

22. How would you describe your political views?

_____ Conservative
_____ Moderate
_____ Liberal

23. What is your race?

_____ White
_____ African American
_____ Asian
_____ Native American
_____ Other

24. What is your marital status?

_____ married
_____ divorced
_____ separated
_____ widowed
_____ single

25. Do you have any children?

_____ Yes
_____ No

26. What is the gross annual income of your household?

_____ Less than $10,000
_____ $10,000 to $19,999
_____ $20,000 to $29,999
_____ $30,000 to $39,999
_____ $40,000 to $49,999
_____ $50,000 to $59,999
_____ $60,000 to $69,999
_____ $70,000 to $79,999
_____ $80,000 or more

27. What is your occupation? _____

REFERENCES

Achille, Marie A. and James R. P. Ogloff. 1997. "When is a Request for Assisted Suicide Legitimate?: Factors Influencing Public Attitudes toward Euthanasia." *Canadian Journal of Behavioral Science* 29(1):19-27.

Adams, Gerald R., Nancy Bueche, and Jay D. Schvaneveldt. 1978. "Contemporary Views of Euthanasia: A Regional Assessment." *Social Biology* 25(1):62-68.

Addington-Hall, Julia and Clive Seale. 1994. "Euthanasia: Why People Want to Die Earlier." *Social Science and Medicine* 39(5):647-54.

Almgren, Gunnar. 1993. "Living Will Legislation, Nursing Home Care, and the Rejection of Artificial Nutrition and Hydration: An Analysis of Bedside Decision-Making in Three States." *Journal of Health and Social Policy* 4(3):43-63.

American Association of Suicidology: Commitee on Physician-Assisted Suicide and Euthanasia. 1996. "Report of the Committee on Physician-Assisted Suicide and Euthanasia." *Suicide and Life-Threatening Behavior* 26(3):2-19.

Armstrong, Jane, Peter Singer, Sujit Choudhry, Eric Meslin, and Frederick Lowery. 1995. "Public Opinion Regarding End-of-Life Decisions: Influence of Prognosis, Practice and Process." *Social Science and Medicine* 41(11):1517-21.

Asch, D. 1996. "The Role of Critical Care Nurses in Euthanasia and Assisted Suicide." *New England Journal of Medicine* 334:1374-79.

Bachman, Jerald G., Kirsten H. Alcser, David J. Doukas, Richard, Lichenstein, Amy D. Corning, and Howard Brody. 1996. "Attitudes of Michigan Physicians and the Public toward Physician-Assisted Suicide and Voluntary Euthanasia." *New England Journal of Medicine* 334(5):303-09.

Back, Anthony L., Jeffrey I. Wallace, Helen E. Starks, and Robert A. Pearlman. 1996. "Physician-Assisted Suicide and Euthanasia in Washington State." *Journal of the American Medical Association* 275(12):919-25.

Berger, Peter L. 1969. *The Sacred Canopy: Elements of a Sociological Theory of Religion.* Garden City, NY: Anchor.

Branco, Kenneth, Joan Teno, and Vincent Mor. 1995. "Advanced Care Planning among Nursing Home Residents Prior to the Patient Self-Determination Act." *Journal of Health and Social Policy* 7(1):37-52.

Brown, J. H., P. Henteleff, S. Barakat, and G. J. Rowe. 1986. "Is It Normal for Terminally Ill Patients to Desire Death?" *American Journal of Psychiatry* 143:208-11.

Burnell, George. 1993. *Final Choices: To Live or Die in an Age of Medical Technology.* New York: Plenum.

Caddell, David P. and Rae R. Newton. 1995. "Euthanasia: American Attitudes toward the Physician's Role." *Social Science and Medicine* 40(12):1671-81.

Callahan, Daniel. 1987. *Setting Limits: Medical Goal in an Aging Society.* New York: Simon and Schuster.

Callahan, Jay. 1994. "The Ethics of Assisted Suicide." *Health and Social Policy* 19(4):237-44.

Cantor, Norman L. 1989. "The Permanently Unconscious Patient, Non-Feeding and Euthanasia." *American Journal of Law and Medicine* 15(4):381-437.

Carter, Stephen L. 1993. *The Culture of Disbelief: How American Law and Politics Trivialize Religious Devotion.* New York: Anchor.

CeloCruz, Maria T. 1992. "Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?" *American Journal of Law and Medicine* 18(4):369-94.

Churchill, Larry R. and Nancy M. P. King. 1997. "Physician Assisted Suicide, Euthanasia, or Withdrawal of Treatment." *British Medical Journal* 19 July:137-38.

Cicireli, Victor G. 1997. "Elder's End-of-Life Decisions: Implications for Hospice Care." *The Hospice Journal* 12(1):57-72.

Coakley, Davis and Conor Maguire. 1997. "Octogenarians and Beyond: What Eventually Kills the Oldest of the Old." *Irish Medical Journal* 90(6) [journal on-line], available at <http://www.imj.ie/issue05/ed1elderlydepress.htm> accessed on 13 September, 1998.

Committee on Medical Ethics: Episcopal Diocese of Washington, D.C. 1997. *Assisted Suicide and Euthanasia: Christian Moral Perspectives*. Harrisburg, PA: Morehouse.

Denk, Charles E., John M. Benson, John C. Fletcher, and Tina M. Reigel. 1997. "How Do Americans Want to Die? A Factorial Vignette Survey of Public Attitudes about End-of-life Medical Decision-Making." *Social Science Research* 26(1):95-120.

Domino, George. 1985. "Clergy's Attitudes toward Suicide and Recognition of Suicide Lethality." *Death Studies* 9:187-99.

Donahue, Michael J. 1993. "Prevalence and Correlates of New Age Beliefs in Six Protestant Denominations." *Journal for the Scientific Study of Religion* 32(2): 177-84.

Durkheim, Emile. [1897] 1975. *Durkheim on Religion,* translated by W. Pickering. Boston, MA: Routledge and Kegan.

_____. [1915] 1965. *The Elementary Forms of the Religious Life,* translated by Joseph W. Swain. New York: Free Press.

Fahy, S. 1997. "Depression in the Elderly Revisited." *Irish Medical Journal* 90(6) [journal on-line], available at <http://www.imj.ie/issue05/ed1elderlydepress.htm> accessed on 13 September, 1998.

Fletcher, Joseph. 1975. "The 'Right' to Live and the 'Right' to Die." Pp. 44-56 in *Beneficent Euthanasia,* edited by Marvin Kohl. Buffalo, NY: Prometheus.

Flynn, Eileen. 1990. *Hard Decisions: Foregoing and Withdrawing Artificial Nutrition and Hydration.* Kansas City, MO: Sheed and Ward.

Forde, Reidun, Olaf Gjerlow Aasland, and Erik Falkum. 1997. "The Ethics of Euthanasia: Attitudes and Practice among Norwegian Physicians." *Social Science and Medicine* 45(6):887-92.

Fung, K. K. 1993. "Wealth Transfer through Voluntary Death." *Journal of Health and Social Policy* 5(2)77-86.

Gelo, Florence, Linda O'Brien, and Bonnie O'Conner. 1997. "Nursing Home Residents' Perception of the 'Good Death.'" *Journal of Religious Gerontology* 10(2):19-27.

Glock, Charles and Rodney Stark. 1965. *Religion and Society in Tension.* New York: Rand McNally.

Gorman, Martha and Carolyn S. Roberts. 1996. *Euthanasia: Contemporary World Issues.* Santa Barbara, CA: ABC-CLIO.

Gula, Richard M. 1986. *What Are They Saying about Euthanasia.* New York: Paulist.

Hammond, Phillip E. 1996. "Conscience and the Establishment Clause: The Courts Remake the Sacred." *Journal for the Scientific Study of Religion* 35(4):357-67.

Hanks, Roma Stovall. 1995. "The Limits of Care: A Case Study of Legal and Ethical Issues in Filial Responsibility." *Marriage and Family Review* 21(3-4):239-57.

Hardwig, John. 1997. "Is There a Duty to Die." *Hastings Center Report* 27(2):34-42.

Hemlock Society. 1995. [WWW Web Site]. Last updated 20 August, 1998. Available at <http://www2.privatei.com/hemlock/opins.html> accessed on 25 September, 1998.

Hertel, Bradley R. and Michael Hughes. 1987. "Religion and Family Issues." *Social Forces* 65(3):858-81.

Holden, J. 1992. "Demographics, Attitudes, and Afterlife Beliefs of Right-to-Life and Right-to-Die Organization Members." *Journal of Social Psychology* 12(5):521-27.

Hopkins, Patricia D. 1997. "Why Does Removing Machines Count as 'Passive' Euthanasia?" *Hastings Center Report* 27(3):29-37.

Hopper, Dale. 1998a. "A Matter of Life or Death." *The Courier-Journal* 22 September, p. B-2.

_____. 1998b. "Hugh Finn's Family Drops Fight against Ending Life Support." *The Courier-Journal* 29 September, p. B-1.

Huber, Ruth, Virginia Meade Cox, and William Edelen. 1992. "Right-to-Die Responses Random Sample of 200." *The Hospice Journal* 8(3):1-19.

Jamison, Stephen. 1995. *Final Acts of Love.* New York: G. P. Putnam.

Jordan, Anne K. 1994. *Comparison of Attitudes towards Death Issues: Euthanasia, Suicide, and Capital Punishment.* Unpublished master's thesis. College Station, PA: Department of Sociology, Pennsylvania State University.

Kaplan, Kalman J. and Matthew B. Schwartz, eds. 1998. *Jewish Approaches to Suicide, Martyrdom, and Euthanasia.* Northvale, NJ: Jason Aronson.

Kelner, Merrijoy. 1995. "Activists and Delegators: Elderly Patients' Preferences about Control at the End of Life." *Social Science and Medicine* 41(4):537-45.

Kohl, Marvin. 1974. *The Morality of Killing.* New York: Humanities.

Lee, Melinda A., Heidi D. Nelson, Virginia P. Tilden, Linda Ganzini, Terri A. Schmidt, and Susan W. Tolle. 1996. "Legalizing Assisted Suicide - Views of Physicians in Oregon." *The New England Journal of Medicine* 334(5): 310-15.

Lynn, Joanne. 1999. "Should Physician-Assisted Suicide be Legalized by the States: 'Suicide' Issue Diverts Us from the Real Problems." *American Association of Retired Persons Bulletin.* May, pp. 29, 31.

Madan, T. N. 1992. "Dying with Dignity." *Social Science and Medicine* 35(4):425-32.

Markides, K. S. 1983. "Aging, Religiosity, and Adjustment: A Longitudinal Analysis." *Journal of Gerontology* 38: 621-25.

McKhann, Charles F. 1999. "Should Physician-Assisted Suicide be Legalized by the States: Some Dying Patients Need Such Help." *American Association of Retired Persons Bulletin*. May, pp. 29, 31.

McDonald, William L. 1998a. "Situational Factors and Attitudes toward Voluntary Euthanasia." *Social Science and Medicine* 46(1):73-81.

_____. 1998b. "The Difference between Blacks' and Whites' Attitudes toward Voluntary Euthanasia." *Journal for the Scientific Study of Religion* 37(3):411-26.

Meier, D. E., C. A. Emmons, S. Wallenstein, T. Quill, R. S. Morrison, and C. K. Cassel. 1998. "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States." *New England Journal of Medicine* 338(17): 1193-201.

Morgan, Rebecca C. and D. Dixon Sutherland. 1997. "Society's Search for a Legal and Ethical Basis of Physician-Assisted Suicide." *Journal of Aging and Social Policy* 9(4):51-70.

National Vital Statistics Report. 1998. *Top Killers of 1997.* 7 October, 47(4):7.

Osman, Hana and Terry M. Perlin. 1994. "Patient Self-Determination and the Artificial Prolongation of Life." *Health and Social Work* 19(4):245-52.

Payne, Sheila, Richard Hillier, Alison Langley-Evans, and Tony Roberts. 1996. "Impact of Witnessing Death on Hospice Patients." *Social Science and Medicine* 43(12):1785-94.

Perrin, Robin D. 1989. "American Religion in the Post-Aquarian Age: Values and Demographic Factors in Church Growth and Decline." *Journal for the Scientific Study of Religion* 28(1):75-89.

Post, Stephen. 1991. "Euthanasia, Senicide, and the Aging Society." *Journal of Religious Gerontology* 8(1):57-65.

Quill, Timothy E. 1994. "Physician-Assisted Death: Progress or Peril?" *Suicide and Life-Threatening Behavior* 24(4):315-25.

Rachels, James. 1986. *The End of Life.* Oxford, England: Oxford University.

Rokeach, Milton. 1968. *Beliefs, Attitudes, and Values.* San Francisco, CA: Jossey-Bass.

Sampaio, Leonard. 1992. "To Die with Dignity." *Social Science and Medicine* 35(4):433-41.

Schonwetter, Ronald S., Robert M. Walker, and Bruce E. Robinson. 1995. "The Lack of Advance Directives among Hospice Patients." *The Hospice Journal* 10(3):1-11.

Singer, Peter. 1979. "Unsanctifying Life." Pp. 41-61 in *Ethical Issues Related to Life and Death,* edited by John Ladd. New York: Oxford University.

Singh, B. K. 1979. "Correlates of Attitudes toward Euthanasia." *Social Biology* 26(1)247-54.

Somerville, Magaret A. 1996. "Genetics, Reproductive Technologies, Euthanasia, and the Search for a New Societal Paradigm." *Social Science and Medicine* 42(12): ix-xii.

Tamney, Joseph B., Ronald Burton, and Stephen Johnson. 1988. "Christianity, Social Class, and the Catholic Bishops' Economic Policy." *Sociological Analysis* 49(S):78-96.

Thal, A. E. 1992. "Should 'Assisted Suicide' be Legalized?" *National Assosciation of Social Workers News* May, p. 4.

Thomlinson, Ralph. 1976. *Population Dynamics: Causes and Consequences of World Demographic Change,* 2nd ed. New York: Random House.

U. S. Census Bureau. 1995. "Aging of the U. S. Population," available at <http://www.census.gov> accessed on 10 September, 1998.

Vernon, Glenn M. 1962. *Sociology of Religion.* New York: McGraw-Hill.

Weber, Max. [1922] 1964. *The Sociology of Religion,* 4th ed. Toronto, Canada: S. J. Reginald Saunders

Werth, James L., Jr. 1999. "The Role of the Mental Health Professional in Helping Significant Others of Persons Who Are Assisted in Death." *Death Studies* 23(3):239-55.

Wesley, Carol A. 1996. "Social Work and End-of-Life Decisions: Self-Determination and the Common Good." *Health and Social Work* 21(2):115-21.

Yates, Jeffrey L. and Henry R. Glick. 1997. "The Failed Patient Self-Determination Act and Policy Alternatives for the Right to Die." *Journal of Aging and Social Policy* 9(4):29-50.

Zalman, Marvin and Steven Stack. 1996. "The Relationship between Euthanasia and Suicide in the Netherlands: A Time Series Analysis, 1950-1990." *Social Science Quarterly* 77(3):577-93.