

**LIVE OR LET DIE: PERCEPTIONS OF CANADIAN PSYCHOLOGISTS ON
ASSISTED DEATH**

SARAH KARESA

B.A., University of Alberta, 2013

A Thesis
Submitted to the School of Graduate Studies
of the University of Lethbridge
in Partial Fulfillment of the
Requirements for the Degree

MASTER OF EDUCATION
(COUNSELLING PSYCHOLOGY)

FACULTY OF EDUCATION
LETHBRIDGE, ALBERTA

May 2015

LIVE OR LET DIE: PERCEPTIONS OF CANADIAN PSYCHOLOGISTS ON
ASSISTED DEATH

SARAH KARESA

Date of Defense: May 6, 2015

Dr. D. L. McBride Thesis Supervisor	Associate Professor	Ph.D.
--	---------------------	-------

Dr. T. Gunn Thesis Committee Member	Associate Professor	Ph.D.
--	---------------------	-------

Dr. M. Stingl Thesis Committee Member	Associate Professor	Ph.D.
--	---------------------	-------

Dr. I. Marcoux External Examiner University of Ottawa Ottawa, Ontario	Assistant Professor	Ph.D.
--	---------------------	-------

Dr. L. Fowler Chair, Thesis Oral Examination Committee	Professor	Ph.D
--	-----------	------

Dedication

This thesis is dedicated to anyone who has been touched by terminal illness.

Regardless of your stance on assisted death, this thesis is for you.

Abstract

This thesis investigated, through an online survey, (a) the opinions of Canadian registered psychologists on the practice of assisted death, (b) the demographic factors that predict these responses, (c) the knowledge that Canadian psychologists have surrounding assisted death, and (d) the confidence this population has in their abilities and training for assessing competency in those who request assisted death. This research topic is of significant value given that there has been no published data on this topic specific to this target population. In total, 97 participants were recruited from the Canadian Psychological Association Research Portal, Facebook advertising, and provincial and territorial psychological associations. Descriptive and nonparametric statistics were used. The data demonstrated that studied psychologists support physician-assisted death for terminal, but not mental, illness. This support was related to the presence of several demographic variables including religion, professional specialty, and number of years as a registered psychologist. Studied psychologists had limited confidence in their ability to assess the competency of terminally ill individuals. As a result, participants expressed an interest in professional training. Psychologists, in this thesis research, appeared to have limited knowledge regarding the practices that constitute assisted death. This was demonstrated to be inconsistent with the results found in the literature. Implications for this study include a new perspective being added to the debate on assisted death as well recognition that psychologists may have an important role to play in the legalization and regulation of these controversial practices. Future directions for research, policy, and professional development are provided.

Acknowledgements

Writing a thesis is not a journey that one can accomplish alone. Rather, it is through support and collaboration with others that a work of this magnitude is completed.

I would like to first thank my supervisor, Dawn McBride, for believing in me and supporting me through countless setbacks and successes. I have grown substantially as a result of your supervision and have learned lessons that I will never forget.

I would also like to thank my thesis committee members: Thelma Gunn and Michael Stingl. When I was lost in the jungle of my thesis, you helped me to find a way out. As a result, I feel more knowledgeable about quantitative research and the practices that constitute assisted death.

To my incredible family and my wonderful boyfriend—you are the reason that I am here. Without your support, I would have never come to Lethbridge, had the courage to pursue a thesis, or been able to stay motivated for such a long time. This thesis is a testament to the love and care you have shown me.

Last, and by no means least, I would like to thank Lisa Halma and Shanaya Nelson. I cannot express enough gratitude for the work you contributed to this thesis. Without the both of you, I might have lost my mind early in the thesis process.

Table of Contents

Dedication	iii
Abstract	iv
Acknowledgements	v
Table of Contents	vi
List of Tables	xiv
Chapter 1: Definitions	1
Assisted Death	1
Assisted Suicide	2
Active Euthanasia	2
Passive Euthanasia	3
Voluntary Euthanasia	3
Nonvoluntary Euthanasia	4
Involuntary Euthanasia	4
Medical Aid in Dying	5
Competence	5
Consent	6
Chapter 2: Introduction to the Issue	7
Statement of the Problem	7
Purpose of the Study	12
Rationale for Question 1: What are the personal and professional perceptions of Canadian psychologists on assisted death?	13

Rationale for Question 2: How do demographic factors predict the perceptions of Canadian psychologists on assisted death?	14
Rationale for Question 3: What preliminary knowledge do Canadian registered psychologists possess surrounding the practice of assisted death?	15
Rationale for Question 4: To what extent do Canadian registered psychologists feel confident in their abilities and training for assessing the competency of individuals requesting assistance in dying?	16
Thesis Overview	17
Chapter Summary	17
Chapter 3: Assisted Death in the Literature	19
Definitions.....	19
Active and passive euthanasia	20
Active euthanasia	20
Passive euthanasia.....	21
Active or passive?	23
Physician-assisted suicide.....	24
Voluntary euthanasia	25
Involuntary and nonvoluntary euthanasia	26
Summary	27
A Global Perspective	28
The Netherlands	29
Belgium.....	31

Luxemburg.....	32
United States	33
Canada.....	34
Summary	38
Perceptions on Assisted Death.....	39
Public	40
Patients.....	41
Physicians	43
Psychologists.....	45
Code of ethics	47
Principle I: Respect for the dignity of persons.....	47
Principle II: Responsible caring.....	47
Principle III: Integrity in relationships.....	48
Principle IV: Responsibility to society	49
Best practice as a psychologist	49
Summary	50
Chapter Summary	51
Chapter 4: Methods.....	52
Participants.....	52
Inclusion and Exclusion Criteria.....	53
The Survey on Death and Dying.....	54
Procedure	59
Ethical clearance	59

Informal testing	59
Recruitment.....	59
Consent	60
Data collection, storage, and destruction	60
Analysis.....	61
Descriptive statistics	61
Nonparametric statistics.....	62
Reliability.....	64
Summary	64
Chapter 5: Results	66
Instrument Reliability	66
Internal consistency	66
Split-half reliability.....	67
Participant Information	67
Age and gender	67
Province of residence.....	67
Professional specialty.....	68
Location of practice	70
Number of years in practice.....	70
Religion and spirituality.....	71
Experience with terminal illness	71
Experience with suicide	72
Addressing the Research Questions.....	73

Research Question 1	73
Descriptive statistics	73
Summary of findings for the vignettes.....	78
Chi-square analysis	78
Research Question 2	79
Descriptive statistics	80
Univariate statistical analysis.....	82
Age.....	82
Gender.....	83
Province of practice	83
Professional specialty.....	83
Location of practice	85
Years in practice	85
Religious and spiritual beliefs.....	85
Supporting terminally ill individuals	86
Suicidal clients.....	86
Professional confidence	89
Research Question 3	89
Descriptive statistics	90
Chi-square analysis	90
Research Question 4	91
Summary.....	92
Chapter 6: Discussion	93

Discussion of the Results	93
Demographic properties.....	93
What preliminary knowledge do Canadian registered psychologists possess surrounding the practice of assisted death?	94
To what extent do Canadian registered psychologists feel confident in their abilities and training for assessing the competency of individuals requesting assistance in dying?	96
What are the personal and professional perceptions of Canadian psychologists on assisted death?	97
How do demographic factors predict the perceptions of Canadian psychologists on assisted death?	100
Age	100
Gender.....	101
Province of residence.....	102
Professional specialty.....	103
Location of practice	104
Years of practice	104
Religious or spiritual beliefs	104
Experiences with terminally ill clients.....	105
Experiences with suicidal clients	105
Professional confidence	106
Summary	106
Overall conclusions.....	107

Strengths of the Research.....	108
Limitations of the Research	109
Future Directions for Research	113
Dementia as atypical assisted death.....	113
Perceptions of psychologists on pain management	115
Qualitative research on psychologists and assisted death.....	117
Perceptions of euthanasia on those with limited competency	118
Future Directions for Policy.....	118
A shift away from medicalization.....	119
A shift in language	120
Future Directions for Psychologists.....	120
Training.....	120
Ethical practice.....	122
A feminist bioethics approach to best practice	123
Conclusion	125
References.....	126
Appendices.....	144
A: Facebook Advertisement	144
B: Canadian Psychological Association and Provincial/Territorial Association Advertisement	146
C: On Death and Dying Survey	147
D: Letter of Human Subject Research Approval	160
E: Participant Consent Form	161

F: Cross Tabulation for Psychologist Perceptions	164
G: Kendell's Tau-b Rank Correlation for Practice Location	188
H: Spearman's Rho Correlation of Years of Practice	193

List of Tables

Table 1	Frequency Distribution for Question 4 – Participants’ Province of Residence.....	68
Table 2	Frequency Distribution for Question 5 – Professional Specialties Participants Most Identified With	69
Table 3	Frequency Distribution for Question 7 – Participants’ Location of Practice	70
Table 4	Frequency Distribution for Question 8 – Participants’ Number of Years in Practice	71
Table 5	Frequency Distribution for Questions 10 to 12 – Participants’ Level of Religion and Spirituality	72
Table 6	Frequency Distribution for Question 17 – Participants’ Perceptions on the Right to Refuse Medical Treatment	74
Table 7	Frequency Distribution for Question 18 – Participants’ Perceptions on the Right to Receive Assistance in Dying	74
Table 8	Frequency Distribution for Vignette 1 – Individual with a Terminal Illness	76
Table 9	Frequency Distribution for Vignette 2 – Individual with a Mental Illness	77
Table 10	Chi-Square Analysis Comparing Psychologist Perceptions and the Rule of Thirds.....	79
Table 11	Kendall’s Tau-b Rank Correlation Coefficient for Participants’ Professional Specialty and Vignette 2.....	84
Table 12	Kendall’s Tau-b Rank Correlation Coefficients of Participants’ Religious or Spiritual Beliefs and Perceptions of Assisted Death.....	87
Table 13	Frequency Distribution of Psychologist’s Knowledge	89
Table 14	Chi Square Test of Psychologist Knowledge	90
Table 15	Frequency Distribution of Psychologist’s End-of-Life Competency.....	91

Chapter 1: Definitions

The intent of this definitions chapter is to provide the reader with a basic framework for thinking about medical decisions that may shorten life. Clear identification of terminology is essential because different definitions in this area of biomedical ethics, according to Downie (2004), serve as the basis for many disagreements and “superficial arguments” (p. 6). In order to avoid such argumentative pitfalls, the following 10 definitions will be introduced in this chapter: assisted death, assisted suicide, active euthanasia, passive euthanasia, voluntary euthanasia, nonvoluntary euthanasia, involuntary euthanasia, competence, and consent. Further discussion surrounding the different concepts involved can be found in the “Definitions” section of Chapter 3.

Assisted Death

In my thesis, I have opted to use the definition of assisted death provided by Downie (2004). According to Downie, assisted death is an “umbrella term for [a] death that requires an intentional act or omission [from] a second person” (p. 6). Assisted death includes voluntary, nonvoluntary, and involuntary euthanasia as well as active euthanasia, the withdrawal of life supporting treatment, and physician-assisted suicide. I chose to use this definition because of its frequent use in the literature as well as its ease of understanding for the lay public. Over the course of this thesis, I will primarily focus on physician-assisted death: the death of an individual at the hands of a physician, such as when a physician (a) provides an injection of potassium chloride with the intention of ending the individual’s life, (b) provides medication with instructions on a lethal dosage, or (c) removes an individual from a ventilator in accordance with an advance directive.

This is in accordance with the individual's perception of the best treatment option (Rachels, 1994). I focus on this form of assisted death because it is the method that appears to be most discussed in the literature.

Assisted Suicide

Assisted suicide is “the act of intentionally killing oneself with the assistance (i.e., the provision of knowledge and/or means) of another” (Downie, 2004, p. 6). While anyone can, ignoring the legal and moral context, assist another in completing suicide, I will focus on physician-assisted suicide. In this form of suicide, it is the physician who provides the knowledge and/or means for an individual to end his or her life. An example relevant to my research is a medical doctor who provides a terminally ill individual with medication and instructions for what constitutes a lethal dose. An important distinction is that the physician is not administering the means for ending an individual's life; the doctor is not acting in a manner that would bring about the death of the individual with terminal illness. This, according to my definition, would be active euthanasia performed by a physician. I have chosen to focus on physician-assisted suicide because it is commonly studied alongside active euthanasia.

Active Euthanasia

Active euthanasia (i.e., active assisted death) is the primary focus of my thesis. I have chosen to use the definition provided by Downie (2004) because she described both the ending of suffering as well as the decision not to prolong life. According to Downie, active euthanasia is “an act taken by one person with the motive of relieving another person's suffering and the knowledge that the act will end the life of that person” (p. 6). Two examples of active euthanasia include a physician providing an injection of

potassium chloride or a family member using a pillow to suffocate a terminally ill individual. As stated previously, I will focus on the physician-assisted form of the practice because of its frequency of discussion in the literature.

Passive Euthanasia

I have chosen to include passive euthanasia (i.e., passive assisted death) as a form of physician-assisted death for the purpose of this thesis. This is an area of contention in the literature because many scholars disagree with the distinguishing of this practice (Somerville, 2001; Sommer, 2008; Varelius, 2013). I have chosen to make this distinction in order to reinforce the complexity of assisted death to the lay public and to reinforce Rachels' (1994) position that active euthanasia is morally equivalent to the withdrawing or withholding of treatment. Passive euthanasia refers to the withdrawal or withholding of life-saving treatment with the intention of ending the life of another and/or relieving an individual's suffering (Tulloch, 2005). For example, removing an individual from life support with the expressed consent of the terminally ill individual and his or her family. In this thesis, passive euthanasia will not be considered a form of euthanasia; rather, it will represent a form of physician-assisted death for the remainder of this thesis. Knowledge and perceptions of this form of assisted death, as well as active euthanasia and physician-assisted suicide, are evaluated in this exploratory study.

Voluntary Euthanasia

I have chosen to focus on voluntary euthanasia, as opposed to the nonvoluntary and involuntary forms, for the purposes of my thesis. This will serve to limit the scope of my thesis and focus on the legal instances of assisted death around the world that highlight consent: an important ethical standard outlined by the *Canadian Code of Ethics for*

Psychologists (Canadian Psychological Association, 2000). I have chosen to use the definition provided by Downie (2004) referring to the provision of assisted death “in accordance with the wishes expressed by a competent person or through a valid advance directive” (p. 7). An example of voluntary euthanasia would be a terminally individual who requests assistance from a physician in dying.

Nonvoluntary Euthanasia

Consistent with the work of Downie (2004), I have chosen to define nonvoluntary euthanasia (i.e., nonvoluntary assisted death) as the provision of assisted death “without the knowledge or wishes of a competent or incompetent person” (p. 7). For example, a physician administers a lethal dose of morphine with the intention of ending the life of a terminally individual and without knowing the person’s perspective. This is different than involuntary euthanasia because the wishes of the individual receiving assistance in dying are not known.

Involuntary Euthanasia

I have chosen to distinguish involuntary, voluntary, and nonvoluntary euthanasia for the purposes of my thesis. The intention behind including these definitions is to provide lay people with an appreciation of consent in relation to assisted death. In addition, these definitions may provide readers with a foundation for understanding the slippery slope argument. I have chosen to use Downie’s (2004) definitions; she referred to involuntary euthanasia as the provision of assisted death “against the wishes expressed by a competent person or through a valid advance directive” (p. 7). This category of assisted death would include, for example, a family member who pushes for the removal of life support despite a valid advance directive.

Medical Aid in Dying

I have chosen to use the definition for medical aid in dying provided by the province of Québec to describe the process whereby a terminally ill individual is able to receive assistance in dying. According to Bill 52: An Act Respecting End of Life Care (2014), a consenting physician first administers medical aid with the intention of causing death. The physician then cares for the individual until death occurs (Bill 52: An Act Respecting End of Life Care, 2014). This is similar to voluntary active euthanasia in that a physician administers a lethal substance to a terminally ill client. However, unlike voluntary active euthanasia, this practice is considered an extension of healthcare (Curtis, 2013). I have included this definition in my thesis in order to demonstrate, to the lay public, the evolution of assisted death in Canada.

Competence

I have chosen to define competence in the same manner as Downie (2004). In using this term, Downie referred to an individual being “capable of understanding the nature and consequences of the decision being made” (p. 7). It is a fundamental concept in the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000) and a frequent topic of discussion in the euthanasia debate (Neiderjohn & Rogers, 2009). Competence also refers to a psychologist’s ability to provide effective services, engage in self-care, engage in self-monitoring, and receive ongoing supervision, training, and education (Canadian Psychological Association, 2000). I have chosen to use both forms of the word competence in order to engage lay people, psychological professionals, and experts in assisted death in a discussion using a common vernacular. It is my hope

that this will avoid any unnecessary confusion and facilitate the development of knowledge for all readers.

Consent

I have chosen to define consent prior to the introduction of this thesis because it is fundamental to understanding the psychological and assisted death literature. Consent refers to a collaborative agreement reached between two parties that strive to protect individual autonomy (Crowhurst & Dobson, 1993). For my thesis it is important to note that consent is not synonymous with agreeing to a practice. Several conditions need to met in order for consent to be considered valid. According to Tymchuk (1997), an individual must display understanding, voluntariness, and competence in decision making. This differentiates consent from a request for assisted death or an agreement with an individual lacking competence. An individual who lacks competence, for example, would be able to make a request for assisted death but would be unable to provide consent.

Chapter 2: Introduction to the Issue

In recent months, assisted death has once again become a fiercely debated topic within Canadian society. Many government officials, medical professionals, and members of the general public have had to question their opinions on issues in which there are no immediately right or wrong answers. Do terminally ill individuals have the right to end their own lives? If they cannot end their own lives, due to disability or severity of illness, can they receive assistance in this act? Under what conditions is active euthanasia, or other forms of assisted death, acceptable and when is it something to be outlawed? In this chapter, the debate on assisted death is discussed. Subsequently, the purpose and direction of this thesis is explored with regard to active euthanasia and other practices under assisted death. It is important to note that the literature presents many conflicting opinions about the legality and morality of assisted death. For the duration of this thesis, the researcher took a neutral stance in the exploration, experimentation, and discussion surrounding this issue.

Statement of the Problem

Around the world, assisted death is considered a complicated and controversial issue. The concept of active euthanasia is particularly complex because the term has traditionally existed in many forms (Varelius, 2013) and is commonly mistaken for other end-of-life practices (Marcoux, Mishara, & Durand 2007). This procedure is controversial for many individuals because it elicits the fear of a slippery slope, in which vulnerable populations such as the disabled or elderly are pressured into an early death (Shariff, 2012; Stingl, 2010a). Due to its controversial nature, active euthanasia is illegal in most countries. However, the Benelux countries of Belgium, the Netherlands, and

Luxemburg have legalized the practice with the Netherlands and Luxembourg also legalizing physician-assisted suicide (Shariff, 2012). The United States (US) is similar in this regard with the legalization or judiciary approval of physician-assisted suicide in Oregon, Washington, Montana (Schüklenk et al., 2011), Vermont (“Victory in Vermont,” 2013), and New Mexico (Eckholm, 2014).

In Canada, unlike in the US and Benelux countries, active euthanasia and physician-assisted suicide are considered illegal. However, this is expected to change as a result of a recent ruling by the Supreme Court of Canada (see *Carter v. Canada*, 2015). Currently, physician-assisted suicide is considered illegal under sections 14 and 241 of the Criminal Code (1985), in which people are prohibited from inflicting death upon another regardless of whether consent is given (see also Lemmens & Dickens, 2001). Suicide is no longer prosecuted in Canada, but any assistance in this act can lead to federal prosecution and imprisonment (Schüklenk et al., 2011) under the charges of murder or administering a noxious substance (Downie, 2004). Active euthanasia, unlike physician-assisted suicide, is considered culpable homicide under sections 229 and 231 of the Criminal Code (1985). Despite the legislation, which directly prohibits both practices, euthanasia and physician-assisted suicide have been highly debated issues in Canada. This can be accredited to recent court cases and legislation that have put into question how assisted death is conceptualized and legislated in this country.

Sue Rodriguez’s case first established assisted suicide as a source of public debate in the early 1990s (Cormack, 2000). In *Rodriguez v. British Columbia* (1993), a terminally ill woman requested permission from the Supreme Court to receive assistance in dying. She argued that the Criminal Code (1985) violated the Canadian Charter of

Rights and Freedoms (1982) in that only able-bodied individuals can legally end their own lives. As a disabled woman, Ms. Rodriguez could not commit suicide without breaking the law (*Rodriguez v. British Columbia*, 1993). In *Carter v. Canada* (2012), Gloria Taylor put forth the same argument, and a British Columbia court granted her the legal ability end her life.

Another case that is important to the debate on assisted death is that of Robert Latimer. In the case of *R. v. Latimer* (1995), a father ended the life of his young daughter suffering from cerebral palsy—a nonterminal illness. After being brought into court on two separate occasions, he was eventually found guilty of second-degree murder and sentenced to 2 years in jail (*R. v. Latimer*, 1995). Many Canadians disagreed with this outcome on the grounds that this was a compassionate act and not an act of murder (Lemmens & Dickens, 2001). Others, such as individuals with disabilities, feared that this act of nonvoluntary euthanasia was the beginning of a slippery slope (Henderson, 2008).

Another recent source of public debate with regard to assisted death stems from the provincial nature of the Canadian healthcare system. In the summer of 2014, the Province of Québec passed Bill 52: An Act Respecting End of Life Care (2014); this bill allows eligible individuals to receive assistance in dying if they meet certain core criteria. This is the first legislation in Canada to allow medical aid in dying for terminally ill individuals. While the Government of Québec claims that this bill is a part of palliative care, due to potential violations to the Criminal Code (1985), the federal government has objected (Curtis, 2013). However, the Supreme Court of Canada has recently determined that Canadians have a right, under the Charter of Rights and Freedoms (1982), to control

the ending of their own lives (*Carter v. Canada*, 2015). In light of this decision, it is essential that the perceptions of Canadian citizens are made public such that debates surrounding legality focus on the needs of the people rather than the perceptions of government officials.

In the current literature, perceptions of active euthanasia and physician-assisted suicide have been studied in multiple populations. Research on the Canadian public has demonstrated that the majority of Canadians support the practice of active euthanasia with differences occurring between the provinces (Angus Reid Global, 2010). Factors that have been found to influence these attitudes around the world include strong religious beliefs (Givens & Mitchell, 2009; Meier et al., 1998; Moulton, Hill, & Burdette, 2006; Wilson et al., 2013), age (Catt et al., 2005; Emanuel, 2002), conservative political beliefs, and involvement in end-of-life activities (Wilson et al., 2013). The perceptions of terminally ill patients on active euthanasia and physician-assisted suicide euthanasia appear to be similar to that of the public (Emanuel, 2002). Many patients support the practice despite hesitations about the potential abuse by medical professionals (Karlsson, Milberg, & Strang, 2012; Wilson et al., 2007). Factors that have been found to influence these perceptions include a diagnosis of cancer (Emanuel, 2002), no hope for recovery (Georges et al., 2007), and the presence of depression (van der Lee et al., 2005). Unlike the public and patients who show support for the practice, surveyed physicians appear to be opposed to the legalization of active euthanasia and physician-assisted suicide. For example, in a recent vote by the Canadian Medical Association, only 34% of physicians were in favour of opening a dialogue surrounding active euthanasia (Eggertson, 2013). In addition, 90% of its members supported the physician's right to choose, within the

confines of the law, whether or not to participate (Goodman, 2014). Factors that have been found to influence these attitudes include their province of practice (Schüklenk et al., 2011), specialization (Emanuel, 2002), and gender (Levy, Azar, Huberfeld, Siegel, & Strous, 2013).

Currently, no research has been conducted on the views of psychologists surrounding assisted death. Like psychiatrists, who are grouped with physicians for the purposes of research (Emanuel, 2002), psychologists seem to be among the most qualified professionals to provide insight and practical knowledge to the current debate (Galbraith & Dobson, 2000). In the context of legalizing active euthanasia and physician-assisted suicide, psychologists could provide insight into the various correlating mental health factors that may be involved in a request for assistance in dying. For example, many terminally ill individuals experience depression and other mental health concerns toward the end of their lives (Wilson, Curran, & McPherson, 2005). Psychologists are experienced in treating mental illness and have largely contributed to the current research on end-of-life conditions (Galbraith & Dobson, 2000). In addition, when active euthanasia or physician-assisted suicide becomes legalized, psychologists may, alongside psychiatrists, be involved in the determination of individuals' competence in making end-of-life decisions. Countries that have already legalized active euthanasia or physician-assisted suicide have set a requirement that the terminally individual be able to make an informed decision and evaluate options without any bias or external pressure (Schüklenk et al., 2011). Psychologists, not currently involved in the practice of assisted death, can be considered the most qualified to make assessments of patient competence in

this regard, as determining an individual's ability or capability is frequently part of their general duties (Niederjohn & Rogers, 2009).

It is ironic that psychologists are required to report clients intending suicide (Canadian Psychological Association, 2000), yet a case can be made that psychologists are in the best position to determine if an individual has made an informed decision to end his or her life. Psychologists have both the knowledge and practical experience to work with any comorbid mental illness as well as to assess competency. With this level of qualification, it appears that psychologists could contribute greatly to the debate on assisted death. In addition, when legalized, it is possible that psychologists may become involved in the process of assisted death itself. Research on the perceptions of psychologists is, therefore, necessary in order to have a comprehensive and informed perspective in the context of the current debate.

Purpose of the Study

This thesis examined the knowledge and perceptions, both personal and professional, of Canadian psychologists on assisted death. The purpose of this study was to inform the literature in an area where knowledge is lacking and to provide further perspectives to more fully inform the debate. In order to fulfill these objectives, four questions were addressed. These questions reflected the knowledge that is currently in place with other relevant populations (i.e., the Canadian public, the terminally ill, and physicians). The research questions are listed along with a brief rationale for including the question in my thesis. In Chapter 2, additional detail is provided to justify the inclusion of each question. The four research questions were as follows:

1. What are the personal and professional perceptions of Canadian psychologists on assisted death?
2. How do demographic factors predict the perceptions of Canadian psychologists on assisted death?
3. What preliminary knowledge do Canadian registered psychologists possess surrounding the practice of assisted death?
4. To what extent do Canadian registered psychologists feel confident in their abilities and training for assessing the competency of individuals requesting assistance in dying?

Rationale for Question 1: What are the personal and professional perceptions of Canadian psychologists on assisted death? This first research question originated from the literature on the perceptions of the general public, terminally ill, and physicians around the world on active euthanasia and physician-assisted suicide (Emanuel, 2002). In each of these populations, researchers had, on multiple occasions, strived to ascertain the current and changing perceptions of these groups over time in an effort to inform the current political and ethical debate regarding assisted death. In accordance with the literature, this thesis strived to expand and inform the existing body of work on this subject. However, this inquiry was extended to examine not only the personal views, but also the professional views of psychologists on assisted death. The researcher anticipated that the frequencies of the personal and professional views of this population would differ based on the nature of ethical practice. In order to practice ethically, psychologists must be aware of the personal beliefs and values they hold in order to ensure their personal views do not impact their work with a client (Canadian

Psychological Association, 2000). Therefore, psychologists' professional perceptions of assisted death were believed to appear more liberal than their personal views. As no research has been conducted on the views of psychologists to date, this thesis provided new perspectives and insights and expanded the existing body of literature.

Rationale for Question 2: How do demographic factors predict the perceptions of Canadian psychologists on assisted death? The second research question explored whether demographic variables would have an effect on psychologists' perceptions of assisted death. Age was believed to be a factor by the researcher, with older psychologists being less supportive of assisted death than their younger counterparts. This supposition is based on the work of Catt et al. (2005), who found that older adults ($n = 129$) over the age of 75 were less likely to want assistance in dying for themselves than those between the ages of 60 to 74. In addition, psychologists with strong religious views were suspected to be less supportive of assisted death, which would support the work of D. M. Wilson et al. (2013); these researchers found, of 1,203 Albertans studied, those who held strong religious beliefs were less likely to support active euthanasia ($p \leq 0.001$). This relation has also been found in medical doctors, including psychiatrists (Levy et al., 2013) and in the general public (Givens & Mitchell, 2009). D. M. Wilson et al. (2013) also found that being involved in end-of-life treatment decisions was correlated ($p = 0.014$) with individuals' perceptions of active euthanasia. Based on the works cited, psychologists who have experience with end-of-life decisions are suggested to be more supportive of the practice.

Gender was also believed by the researcher to be a factor, with female psychologists potentially being more conservative than males; Levy et al. (2013) found,

in a sample of 103 Israeli physicians, females were less likely to be in support of medically assisted death. This may reflect a cultural paradigm or a difference in gender perceptions. In addition, in this inquiry, psychologists from Québec and British Columbia were expected to be the most permissive of assisted death; this supposition is based on an Angus Reid Global (2010) public opinion poll of 1,003 Canadians, which found that 75% of people in British Columbia and 77% of people in Québec supported active euthanasia as compared to other Canadian provinces (ranging from 51% to 67%). This level of support was higher than with any other province. A final factor that was believed to influence the perceptions of psychologists is their specialization and place of work, with those working in hospitals and health-related fields being more supportive of the practice. This postulation was based on the findings of Meier et al. (1998), who surveyed 3,102 American physicians and found a correlation between physicians' medical specialty and their willingness to provide assistance in dying ($p < 0.001$).

Rationale for Question 3: What preliminary knowledge do Canadian registered psychologists possess surrounding the practice of assisted death? The third research question largely stemmed from the work of Marcoux et al. (2007), who found that while nearly 70% of Canadians surveyed ($n = 991$) supported active euthanasia, many could not distinguish active euthanasia from other forms of assisted death; participants confused euthanasia with physician-assisted suicide (72%), treatment withdrawal (66%), the doctrine of double effect whereby a drug intended to reduce pain kills the patient (49%), and withholding treatment (38%). Marcoux et al. (2007) found participants' confusion to be related to an increased acceptance for the practice when compared to those who could make the correct conceptual or legal distinctions

($\chi^2 = 25.97$). Based on this research, the researcher suspected that psychologists who support the practice of assisted death would not be knowledgeable surrounding the definitions. In this inquiry, the researcher expected participants would demonstrate a lack of knowledge regarding terminology, as there is currently no certification or training programs surrounding work with terminally ill clients (Werth, Lewis, & Richmond, 2009).

Rationale for Question 4: To what extent do Canadian registered psychologists feel confident in their abilities and training for assessing the competency of individuals requesting assistance in dying? Given that psychologists do not appear to receive formal training in end-of-life issues and that competency for psychologists is tied to knowledge gained from training, the researcher anticipated that the surveyed psychologists would rate their competence and confidence in helping people navigate end-of-life issues as being low. The research also predicted that the thesis data would reveal the same trend Marcoux et al. (2007), who found that those who lacked knowledge regarding assisted death also demonstrated the most support. However, this anticipated response contrasts with Galbraith and Dobson's (2000) opinion (no research collected) that suggests psychologists are the professionals with the most knowledge and practical experience to work with the terminally ill. Galbraith and Dobson's view supported the work of Niederjohn and Rogers (2009), who believed that psychologists may be the most qualified to determine the competency of a patient who wishes to end their life.

Thesis Overview

Based on the outline provided in this chapter, Chapter 3 explores the current literature surrounding the assisted suicide debate. First, the practice of assisted death and the many forms that it can take are explored. Second, an examination occurs of active euthanasia and physician suicide in countries where it is legal, as well as in Canada where the legality of active euthanasia has just been decided. In order to understand the Canadian debate more fully, the perceptions of the Canadian public, terminally ill patients, physicians, and psychologists are examined. The intent of providing this information is to set the foundation for this thesis.

Chapter 4 documents the methods that were used to conduct the research involved in this thesis. Furthermore, Chapter 4 includes a reexamination of the research questions, as well as an exploration of how participants were recruited, who could participate in the study, the procedure for collecting data, and the survey instrument that was used. The results of the analyzed data are presented in Chapter 5 of the final report, and tables and figures are used to summarize the data.

Chapter 6 of the final report summarizes the core findings and offers informed interpretations of the research conclusions. Chapter 6 also outlines the strengths and limitations of my thesis. The final chapter concludes by listing areas of improvement and options for future research in the fields of assisted death and psychology.

Chapter Summary

When it comes to discussing assisted death, the profession of psychology seems to have generally ignored this topic in the academic and policy-based literature (Galbraith & Dobson, 2000). According to Niederjohn and Rogers (2009), psychologists are

considered to be some of the most qualified professionals to assess competency and work with terminally ill individuals, yet their perceptions have never been studied. This thesis aimed to fill this gap in the literature by examining the perceptions, knowledge, and self-perceived competencies of psychologists in relation to assisted death. In addition, demographic factors were examined in order to determine the effects that they have on psychologists' views. The following chapters explore these areas, as well as the foundational literature, in great detail. By exploring the perceptions of psychologists on assisted death, the researcher hoped to provide a new and relevant viewpoint to the current debate.

Chapter 3: Assisted Death in the Literature

The literature on assisted death is highly nuanced. How do active euthanasia, physician-assisted suicide, and other currently legal assisted death practices differ? How do people from around the world regard and regulate these practices? How do Canadians perceive, or often misperceive, these practices? This chapter explores the literature on assisted death to provide a foundational understanding of the nuances surrounding the current debate. This chapter defines the different types of assisted death, examines it in its legal form, and reviews it within a Canadian context. This chapter culminates in an exploration of the role of psychologists and why they should be included within the assisted death debate.

Definitions

Assisted death has traditionally been known by many names. Mercy killing, rational suicide, and assisted suicide are all terms used to describe the act of assisting in the death of a terminally ill individual (Vamos, 2012). These terms, while popular, do not accurately reflect the practices involved or the legal, ethical, and philosophical debates regarding the value of human life. As a result, few Canadians surveyed appear to understand the concept of assisted death (Marcoux et al., 2007). To promote informed research and public debate, it is essential that psychologists provide accurate definitions and practices to help eliminate any misunderstandings and ensure that accurate terminology is used. This section explores the following: (a) active and passive euthanasia, (b) physician-assisted suicide, (c) voluntary euthanasia, and (d) involuntary and nonvoluntary euthanasia.

Active and passive euthanasia. This section explores three subtopics. First, active euthanasia is defined and examined, followed by a review of passive euthanasia (i.e., the passive form of physician-assisted death). This section closes with an examination of the controversy that exists surrounding the concept of passive euthanasia.

Active euthanasia. Active euthanasia, the most recognized form, involves a deliberate action being taken toward terminally ill individuals in order to end their lives (Tulloch, 2005). A physician administering a lethal injection, for example, is practicing active euthanasia; the physician is directly acting on the patient with the intention of ending the patient's life. This intention is essential for distinguishing active euthanasia from other forms of medical practice (McCormack, Clifford, & Conroy, 2012). For example, if a physician prescribes a high dose of pain medication to a terminally ill client intending to relieve some of the patient's suffering and the patient dies, although the physician recognized and was aware that the high dose of the medication could cause death in some individuals, as the physician did not intend to end the terminally ill individual's life, this doctor did not practice active euthanasia (Canadian Medical Association, 2007). Instead, the physician practiced according to the doctrine of double effect.

Statistics surrounding the prevalence of active euthanasia are nonexistent in Canada, as the practice has been previously considered illegal. Statistics do exist for Luxemburg, Belgium, and the Netherlands, with all three legalizing the practice by medical professionals (Schüklenk et al., 2011). According to Rurup et al. (2011), 9,363 deaths occurred by active euthanasia between the dates of September 2002 and December 2007 in the Netherlands. This is approximately 5% higher than the number of deaths

found for this same period in Belgium ($n = 1,883$), a potential result of greater tolerance of assisted death, different rates of reporting, and an overall higher number of deaths per year (Rurup et al., 2011). Since enacting legislation, both countries have seen increases in the amount of regulated active euthanasia (Schüklenk et al., 2011). It should be noted, however, that this form of regulated active euthanasia is not the same as physician-assisted suicide, which is discussed in further detail later in this chapter.

Passive euthanasia. Prior to the 1970s, active euthanasia was considered the only form of euthanasia (Beauchamp, 1996). However, passive euthanasia has been identified by some as a second form that elaborates on the healthcare provider's action, or lack of action, taken toward a terminally ill patient (see Downie, 2004; Tulloch, 2005). As indicated in Chapter 1, for the purposes of this thesis, passive euthanasia is considered a form of physician-assisted death. This form of euthanasia involves the withdrawing or withholding of life-sustaining treatment in individuals who wish to end their lives (Tulloch, 2005) or not prolong their suffering. A patient who refuses to be intubated, for example, is undergoing passive euthanasia. The healthcare provider is assisting in the individual's death by not providing the life-sustaining measures that would artificially extend the patient's life. While in most countries active euthanasia is considered illegal, passive euthanasia is considered legal through the patient's right to refuse treatment (McCormack et al., 2012). In Canada and the US all patients have the right to refuse treatment regardless of whether such treatment could extend their lives (Cormack, 2000). In situations in which patients are unable to communicate, they can express their intentions preemptively through legal documents such as advance directives and durable power of attorney (Downie, 2004; Lemmens, & Dickens, 2001). According to Bravo et

al. (2011), research on the advanced planning decisions of Canadians is limited. In a survey of 2,060 individuals from Nova Scotia, Alberta, Ontario, and British Columbia, 46.7% of participants indicated having written their health care preferences in advance. In addition, 69.1% of individuals orally expressed their advance directives to others (Bravo et al., 2011). In the Netherlands, where statistics on medical death are more diligently recorded, nearly 10% of medical deaths were a result of passive euthanasia in 2010 (Statistics Netherlands, 2012). While passive euthanasia may be more common than other assisted death practices (e.g., active euthanasia), researchers and academics argue as to whether passive euthanasia is a form of assisted death at all.

Those who disagree with the inclusion of passive euthanasia as a form of assisted death argue that withholding or withdrawing treatment from a terminally ill individual is just omitting or removing a treatment option that the patient does not want (Vogel, 2012). By law, Canadian physicians must respect the refusals made by individuals who are of sound mind and judgement (Schüklenk et al., 2011). Healthcare providers, therefore, must withdraw or withhold treatment consistent with the patient's request. Further, in engaging in this action, the doctor is believed to not be intending death, but rather upholding legal liability. Under Canadian law, administering treatment to an individual who does not provide consent is considered a form of battery (Crowhurst & Dobson, 1993). Therefore, opponents of the inclusion of passive euthanasia as a form of assisted death argue that, because the physician holds no intention to cause death, withdrawing or withholding of life-sustaining treatment in accordance with the patient's wishes to refuse care is not an act of assisted death.

Active or passive? While this thesis used the terms active and passive for distinguishing forms of assisted death, and for establishing psychologist knowledge, some authors have argued that this should not be the case. Somerville (2001) asserted that making such a distinction dilutes the creation of a clear definition of assisted death, and this lack of clarity has led to the inclusion of practices that unto themselves are not assistance in dying, such as when a physician elects to withhold ineffective treatments or when an individual refuses life-sustaining treatment. These scenarios do not constitute assisted death because the physician's intention is not to cause the patient's death. According to Somerville, acts of assisted death must have a mens rea and actus reus—an intention to cause death and an act or omission that causes the person's death. As such, making the distinction between active and passive euthanasia can be considered artificial (Somerville, 2001); additionally, such definitions may confuse euthanasia with other end-of-life actions (e.g., actions consistent with the doctrine of double effect).

Sumner (2011) also argued against the division of active and passive euthanasia. He stated that this distinction makes the term euthanasia ambiguous such that people's perceptions of the practice cannot be differentiated as support of currently illegal actions or the currently legal withdrawing or withholding of treatment. In addition, Sumner contended that passive euthanasia is not assisted death at all, because it does not involve the administration of treatment. Assisted death must involve the administration of treatment, intention to cause death, and agency on the part of the individual or the physician. Passive euthanasia does not fit these criteria (Sumner, 2011).

Despite these concerns, this thesis has differentiated between active and passive euthanasia, with the purpose being to provide a full appreciation of the controversy and

complications surrounding assisted death. Although this distinction can be ambiguous and may result in confusion surrounding various end-of-life practices (Sumner, 2011), the differentiation serves to emphasize how the issue is not black and white. Regardless of the practice, Rachels (1994) argued that the action is the same—providing the best treatment option consistent with the values of a terminally ill individual. The intention behind the action does not matter such that an individual cannot differentiate one form of assisted death without distinguishing the other. Therefore, active euthanasia cannot be discussed without a discussion of passive euthanasia (Rachels, 1994). For the most part, this thesis has focused on and discussed active euthanasia; however, passive euthanasia must be kept in mind as a legal alternative to providing death or not artificially prolonging life.

Physician-assisted suicide. Many researchers have argued that physicians are not performing active euthanasia if they prescribe, but do not administer, a lethal dose of medication to a patient (Beauchamp, 1996). In this case, the physician is participating in physician-assisted suicide, a practice in which a physician provides the means for a terminally ill individual to end his or her own life (Stingl, 2010b). Researchers have argued over whether this practice should be considered a form of active euthanasia (Varelius, 2013). Although both euthanasia and physician-assisted suicide involve the intention to end the life of an individual suffering from a terminal illness (McCormack et al., 2012), the cause of death differs. In active euthanasia the cause of death is due to the direct action of the physician toward the terminally ill patient, such as when a physician administers a lethal dose of medication (Beauchamp, 1996). In physician-assisted suicide the cause of death is due to an indirect action of the physician, who provides the

terminally ill individual with the means to end his or her own life, such as when a physician prescribes a patient medication with specific instructions on what constitutes a fatal dose (Beauchamp, 1996). Physician-assisted suicide is legal and has been approved by the courts in the Netherlands, Luxemburg, Oregon, Washington, Montana (Schüklenk et al., 2011), Vermont (“Victory in Vermont,” 2013), and New Mexico (Eckholm, 2014). In the US, there has been increased interest in the practice of physician-assisted suicide, with states like Oregon and Washington reporting rates of completed physician-assisted suicide that are, respectively, 4.8 times (Oregon Public Health Division, 2013) and 1.6 times (Washington State Department of Health, 2012) higher than when their laws were first introduced. For the purpose of this thesis, physician-assisted suicide was not considered a form of euthanasia. However, the thesis has discussed this topic, as many people surveyed cannot distinguish between the two practices (Marcoux et al., 2007).

Voluntary euthanasia. Regardless of the form of assisted death, the healthcare provider must consider the person’s level of consent. Voluntary euthanasia involves ending the life of terminally ill individuals with their expressed consent (Tulloch, 2005) after a request has been made. For consent to be considered appropriate, terminally ill individuals must be competent to evaluate their decision and understand the consequences of their actions (Vamos, 2012). In addition, under the doctrine of informed consent, four conditions must be present: the patient must provide assent to treatment, the patient must have the capacity to make the decision, the decision must be voluntary, and the patient must be provided with enough information to make an informed choice (Sumner, 2011). Incompetent individuals (e.g., people suffering from a mental impairment) are considered to be nonconsenting despite any wishes they express that

would indicate otherwise (Schüklenk et al., 2011). This is to protect the individual from receiving a treatment that could cause unwanted harm and suffering (Canadian Medical Association, 2007). Voluntary active euthanasia is central to the current debate on assisted death, as it is the practice that many Canadian advocates strive to legalize. However, opponents disagree with this form of euthanasia, as they believe it leads to other forms of assisted death that do not involve consent.

Involuntary and nonvoluntary euthanasia. Involuntary euthanasia involves assisting in the death of a terminally ill individual who is competent but does not wish to receive euthanasia (Schüklenk et al., 2011). For example, a comatose individual who is taken off life support against his or her wishes expressed through an advance directive. Nonvoluntary euthanasia involves assisting in the death of a terminally ill individual who lacks the capacity to consent (Schüklenk et al., 2011). Providing assistance in dying for a person suffering from a developmental disability, for example, would be considered nonvoluntary euthanasia. In the Benelux countries, all active euthanasia without consent is considered illegal (Schüklenk et al., 2011). However, in Belgium, Chambaere et al. (2010) estimated that 32% of physicians have committed active euthanasia against individuals without their consent. It is clear that the legalization of voluntary euthanasia does not prevent involuntary and nonvoluntary euthanasia from occurring.

According to Shariff (2012), many opponents of assisted death fear that voluntary euthanasia would lead to involuntary and nonvoluntary euthanasia on vulnerable populations. Opponents fear that people who are disabled, mentally ill, or advanced in age would be put most at risk of having death forced upon them (Shariff, 2012). This argument, entitled “the slippery slope argument” (Tulloch, 2005, p. 32), describes the

situation in which something that is a defensible action at one point becomes an unjustifiable action at another. The fear is that voluntary euthanasia (considered by some to be an acceptable act) would gradually evolve into nonvoluntary euthanasia (which many agree is unacceptable) over time. The slippery slope argument has been used by many populations, including medical physicians (Canadian Medical Association, 2007), to oppose the legalization of voluntary euthanasia and physician-assisted suicide. This argument highlights how focusing on an individual's autonomy can have a significant, negative impact on the autonomy of others within society (Somerville, 2001). While this is a strong argument against providing assistance in dying, it assumes that the slippery slope is a certainty rather than a possibility (Shariff, 2012). Although no one can say for certain what will happen when voluntary active euthanasia is legalized in Canada, the Supreme Court of Canada has ruled that slippery slope concerns could be addressed without banning physician-assisted death (*Carter v. Canada*, 2015).

Summary. For the purpose of this thesis, assisted death exists in many forms, each of which varies by level of consent and level of action. Passive and active euthanasia are distinguished by the level of action a healthcare provider takes in assisting a patient to end his or her own life or avoiding prolonging the patient's life at his or her request. Physician-assisted suicide involves the same intent, but differs according to the action involved. Voluntary, involuntary, and nonvoluntary euthanasia are defined by the level of consent provided by the terminally ill individual. This thesis has focused on voluntary active euthanasia and voluntary physician-assisted suicide, as they are the most controversial in relation to the slippery slope argument, and the most debated.

A Global Perspective

In the discussion of assisted death, it is useful to make comparisons between countries. The Royal Society of Canada Expert Panel on End of Life Decision Making drew comparisons between the perceptions of physician-assisted death across several countries in order to develop their own perception of the practice (Schüklenk et al., 2011). When comparing countries on their legal and social perceptions surrounding assistance in dying it is important to recognize that no two countries are identical. While countries may appear similar, they differ in how they are shaped by their unique cultures, religions, economic systems, and beliefs (Mendelson & Jost, 2003). This is especially true with regard to populace's views on assisted death.

According to Shariff (2012), two countries within the European Union—the Netherlands and Luxemburg—have legalized both euthanasia and physician-assisted suicide. Belgium has legalized only euthanasia (Shariff, 2012). According to Mendelson and Jost (2003), these countries exist as unitary systems in which one central government regulates the whole population. This is different than in the US and Canada, where regulation of the population occurs at both the federal and provincial or state levels. Additionally, the Netherlands, Belgium, and Luxemburg are legislated by national codes, whereas the US and Canada employ systems of common law in which codes and judiciary precedents form the basis for legislation (Mendelson & Jost, 2003). Therefore, while it is important to discuss the Netherlands, Belgium, and Luxemburg for their legalization of euthanasia, comparisons are limited because of the differences in their system of government. Even the US, which is commonly compared to Canada, is not a perfect comparison, because Americans do not have universal healthcare (Blendon et al.,

2002). Instead, the US has a multitiered healthcare system, which is only applicable to those who buy relevant insurance from the government (Maioni, 2014). Despite these limitations, examinations were made of the Benelux countries and the US. This has provided a context for a discussion of the current state of assisted death in Canada.

The Netherlands. Prior to the legalization of active euthanasia and physician-assisted suicide, both acts were considered illegal under the Dutch Criminal Code (Mendelson & Jost, 2003). According to Schüklenk et al. (2011), very few physicians were charged under this code because many met the criteria for a “defense of necessity” (p. 51). This defense is based out of Section 40 of the Dutch Criminal Code and states that people can commit crimes if they are under pressure and cannot refuse (Schüklenk et al., 2011). Many physicians claimed this defense and avoided prosecution. In response, the government began discussions on the legality of active euthanasia and physician-assisted suicide (Mendelson & Jost, 2003). In 1990, the government implemented a process of reporting instances of active euthanasia and physician-assisted suicide and, in 2002, the government amended the Dutch Criminal Code to legalize both of these acts (Legemaate, 2004).

Currently, persons in the Netherlands over the age of 18 and experiencing unbearable subjective suffering from a physical or mental illness can ask for death by a physician (Shariff, 2012). However, physicians are given the right to choose whether or not they grant the request (Mendelson & Jost, 2003). It is a professional choice as to whether a physician agrees to provide assistance in dying for the patient. According to Schüklenk et al. (2011), physicians who choose to assist a patient in dying must adhere to six due care criteria.

The attending physician must:

1. be satisfied that the patient has made a voluntary and carefully considered request;
2. be satisfied that the patient's suffering was unbearable, and that there was no prospect of improvement;
3. have informed the patient about his situation and his prospects;
4. have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient's situation;
5. have consulted at least one other, independent physician, who must have seen the patient and given a written opinion on the due care criteria referred to in 1–4 above; and
6. have terminated the patient's life or provided assistance with suicide with due medical care and attention. (Schüklenk et al., 2011, p. 77)

In addition to these criteria, several considerations need to be made in cases in which people who are incompetent request assistance in dying. According to Mendelson and Jost (2003), if a minor between the ages of 16 and 18 requests active euthanasia or physician-assisted suicide, the physician must consult the parents or guardians in addition to following the due care criteria. Between the ages of 12 to 16 parental or guardian consent for such requests is required (Mendelson & Jost, 2003). When a person has a mental illness, the physician must consult with a psychiatrist to ensure that the person is able to make a competent and voluntary decision (Shariff, 2012). In the Netherlands, it is believed that mental illness does not always cause impairment for a patient's ability to make a decision (Gevers & Legemaate, 1998). For example, a person with depression is

not always in a depressed state and, therefore, is able to make decisions when the individual has returned to a state of normal functioning. Therefore, an important consideration in assisted death for mental illness is the current state of functioning for the individual.

Belgium. The legalization of active euthanasia in Belgium began with the practice of physicians. According to Schüklenk et al. (2011), physicians were occasionally ending the lives of their terminally ill patients without their expressed consent. In order to regulate these behaviours and modify how physicians treated their patients, Belgium instituted the Belgian Act in 2002. This act serves only to regulate voluntary active euthanasia; however, in 2004, the Federal Control and Evaluation Committee (as cited in Schüklenk et al., 2011) demonstrated that physician-assisted suicide falls under the umbrella of this law.

Any person over the age of 18 or who is an emancipated minor in Belgium can receive active euthanasia if the individual is suffering physically or mentally from a medical condition (Shariff, 2012). Similar to the Netherlands, any person can receive active euthanasia as long as the condition they have has a medical basis and causes unbearable suffering (Schüklenk et al., 2011). This includes people who are suffering from mental illnesses such as depression (van Hoey, 2014). Among the criteria for establishing the appropriateness of the end-of-life practice is that the patient requesting assistance in dying must be competent and able to make repeated, voluntary requests free from external pressure (Schüklenk et al., 2011). In addition, the patient must be experiencing a severe and hopeless condition due to illness or accident of which there is no hope of recovery (Schüklenk et al., 2011). According to Shariff (2012), if these

criteria are met and agreed upon by two physicians, a person is able to receive active euthanasia. In the case of individuals who are unbearably suffering but not close to dying (e.g., a quadriplegic), a third consultation is deemed necessary (Shariff, 2012).

Recently, Belgium became the first country to allow persons of any age to request assistance in dying from a physician (McDonald-Gibson, 2014). Under this extension to the current legislation, minors can now receive active euthanasia. In order to qualify, minors must be terminally, not mentally, ill and be capable of requesting active euthanasia themselves (Van Hoey, 2014). In addition, a minor's decision must be agreed upon by a team of doctors, psychologists, and caregivers, with the final decision resting with the parents (McDonald-Gibson, 2014). If these parties agree, then the minor's request for active euthanasia can be granted.

Luxemburg. The process of legalizing active euthanasia and physician-assisted suicide in Luxemburg was very different than that of the Netherlands and Belgium. Instead of legislation stemming from a governmental body, two members of the Luxemburg parliament proposed the legislative changes that can be seen today (Schüklenk et al., 2011). In Luxemburg, physician-assisted suicide and active euthanasia have been legal since 2009 (Shariff, 2012). The laws surrounding these practices are similar to that of Belgium and the Netherlands. The main difference is that, according to Shariff (2012), people can only receive active euthanasia if they are adults and suffering physically or mentally from a medically based condition. Together, the laws of the Netherlands, Belgium, and Luxemburg are known as the Benelux Laws (Shariff, 2012). The Benelux laws, while important to recognize in the conversation surrounding assisted

death, do not provide as close of a comparison to the Canadian situation as the United States of America.

United States. The perception of assisted death in the US is very different when compared to the Benelux countries. While there is no legislation directly prohibiting the practice, any attempts at providing active euthanasia are considered murder by the Supreme Court; however, the courts have allowed each state the right to make their own decision regarding physician-assisted suicide (Lemmens & Dickens, 2001). Therefore, each state can create legislation surrounding the practice.

The actions of Oregon created opportunities for other states to regulate physician-assisted suicide. According to Galbraith and Dobson (2000), the Oregon Death with Dignity Act in 1994 started the discussion on the legalization of physician-assisted suicide. Opponents argued in the US Supreme Court that this act violates the Americans with Disabilities Act; however, the court ruled in favour of Oregon such that in 1997 the Death with Dignity Act was officially passed (Galbraith & Dobson, 2000). This made Oregon the first state to legalize the practice of physician-assisted suicide. Oregon was followed by Washington in 2008 (Schüklenk et al., 2011), Montana in 2009 (Winograd, 2012), Vermont in 2013 (“Victory in Vermont,” 2013), and New Mexico in 2014 (Eckholm, 2014).

Unlike in Oregon, Washington, and Vermont, the states of Montana and New Mexico came to permit physician-assisted suicide through state-level judiciary decisions. In Montana, the case of *Baxter v. Montana* (2009) demonstrated that there is no law prohibiting physicians from assisting in suicide. In addition, the Montana Rights of the Terminally Ill Act encouraged patient autonomy and protected all physicians from

liability if they assisted in carrying out someone's end of life request (*Baxter v. Montana*, 2009). A similar process occurred recently in the state of New Mexico. According to Hamedy (2014), a judge ruled that physician-assisted suicide could not be considered a form of suicide. In addition, the act of dying on one's own terms is considered a fundamental aspect of individual liberty (Hamedy, 2014). In both of these states, no legislation officially legalizes physician-assisted suicide; however, such judiciary precedents permit this practice to occur through the system of common law.

In Oregon, Washington, and Vermont, legislation exists to legalize physician-assisted suicide. This legislation stems from the Oregon Death with Dignity Act (as cited in Schüklenk et al., 2011), which specifies several criteria that must be met in order for a person to receive physician-assisted suicide. According to Winograd (2012), a person must have a terminal illness, be medically diagnosed with less than 6 months to live, and have the competency make an informed decision. In addition to these criteria, an oral and written request must be made to their physician. This request must be validated by two other physicians and repeated 15 days later. If this occurs then the terminally ill individual can receive physician-assisted suicide (Winograd, 2012). Unlike in the Benelux countries, physicians cannot directly end the lives of their patients. Instead, they prescribe a lethal dose of medication that must be self-administered by the patient (Winograd, 2012).

Canada. Unlike in the US, Canada has federal legislation that criminalizes the practice of active euthanasia and physician-assisted suicide for its citizens. Section 14 of the Criminal Code (1985) states it is illegal for a person to end the life of another regardless of whether consent was provided (see also Lemmens & Dickens, 2001).

Therefore, a terminally ill individual cannot be provided with assistance with dying even if he or she consents to the practice. Section 241 of the Criminal Code (1985) further states that a person cannot assist or suggest suicide to another under a maximum penalty 14 years in prison (see also Lemmens & Dickens, 2001). While suicide is not a criminal offence, individuals engaging in the act can receive no assistance in seeking death. Specific to active euthanasia, individuals can be charged with culpable homicide under sections 229 and 231 of the Criminal Code (1985). Based on the Criminal Code (1985), the Canadian government has taken a strong position against assistance in dying (Kennedy, 2013). However, recent developments have challenged this position and resulted in a recent ruling by the Supreme Court of Canada in favour of physician-assisted death.

In the summer of 2013, the Province of Québec announced its intention to pass Bill 52: An Act Respecting End of Life Care (2014); according to Bill 52, persons over the age of 18 and capable of consent can request medical aid in dying. These individuals must be experiencing psychological or physical pain in addition to a decline in functioning as a result of a terminal illness. Physicians are not forced to provide aid to a dying individual. Instead, requests for aid are passed onwards to other physicians or organizations that are willing to provide such care (Bill 52: An Act Respecting End of Life Care, 2014). To the federal government, Bill 52 was a direct violation of the criminal code (Curtis, 2013). In addition, this bill violated the government's position of not reopening the debate on assisted death (Yaffe, 2008). The Province of Québec viewed Bill 52 as a healthcare issue that does not fall under federal jurisdiction (Curtis, 2013). In addition, prior to the adoption of Bill 52, an Ipsos Descarie survey (as cited in

“Quebec Specialists,” 2009) found that the majority of Québec physicians support the legalization of assisted death. On June 6, 2014, Bill 52 was passed by members of the parliamentary assembly (Dougherty, 2014). This made Québec the first province in Canada to pass legislation that permits medical aid in dying.

Common law is based on legal precedents and judicial decisions (Mendelson & Jost, 2003). In Canada, there have been several examples of common law that have challenged the country’s stance on assisted death, much like the recent Bill 52 (2014). Recall the case of *Rodriguez v. British Columbia* (1993). In this case, a 42-year-old woman suffering from amyotrophic lateral sclerosis petitioned the court to allow her the right to receive physician-assisted suicide (Galbraith & Dobson, 2000). Ms. Rodriguez argued that Sections 14 and 241 of the Canadian Criminal Code (1985) discriminated against people with disabilities (*Rodriguez v. British Columbia*, 1993). Unlike those without disabilities, people with disabilities are unable to legally commit suicide. The assistance that would be required for them to commit the act would violate the Criminal Code and could result in up to 14 years in prison for the other party. In this way the Criminal Code violates section 15(1) of the Canadian Charter of Rights and Freedoms (1982), which guarantees equality before the law and equal receipt of its benefits (*Rodriguez v. British Columbia*, 1993). Through a narrow margin (5 votes to 4) the Supreme Court ruled against Ms. Rodriguez (Galbraith & Dobson, 2000). They cited Section 1 of the Canadian Charter of Rights and Freedoms, which stipulates the government’s right to place reasonable limits on an individual in order to protect society (Lemmens & Dickens, 2001). The court ruled that limiting Ms. Rodriguez’s access to physician-assisted suicide was protecting the sanctity of life for the greater society

(Galbraith & Dobson, 2000). The courts wished to avoid creating a slippery slope, which would result in discrimination toward vulnerable individuals, and they did not have enough evidence to prove that such an event could be avoided (*Rodriguez v. British Columbia*, 1993). The case of *Rodriguez v. British Columbia* (1993) started the public conversation in Canada about the legalization of active euthanasia and physician-assisted suicide; however, it would be 21 years later when this conversation would begin to take a new turn.

In *Carter v. Canada* (2012), Gloria Taylor and the family of Kathleen Carter petitioned the courts on the same grounds as Sue Rodriguez for the right to have assistance in dying. The difference in their case was that evidence had emerged within the last 21 years that supported the use of safeguards against the development of a slippery slope. Like Ms. Rodriguez, Gloria Taylor, the woman petitioning for the exemption, had amyotrophic lateral sclerosis and wanted to be able to end her life on her own terms. Kathleen Carter suffered from spinal stenosis and travelled to Switzerland to receive assistance in dying. Carter's daughter and husband petitioned the court to allow terminally ill individuals in British Columbia to receive assistance in ending their lives, as they did not want others to suffer as Carter did toward the end of her life (*Carter v. Canada*, 2012). The results of this court case went against the results of *Rodriguez v. British Columbia* (1993). According to Butler, Tiedemann, Nicol, and Valiquet (2013), the judge granted Taylor a constitutional exemption to receive assistance in dying as the relevant sections of the Criminal Code (1985) are in violation of the Canadian Charter of Rights and Freedoms (1982). The federal government has appealed this decision as well as the exemption. This appeal has resulted in the Supreme Court of Canada determining

that Canadians have the right, under the Charter of Rights and Freedoms (1982), to control the ending of their lives (*Carter v. Canada*, 2015). This is a landmark decision, which will, like Bill 52 (2014), provide movement for change regarding assisted death in Canada.

While many active euthanasia and physician-assisted suicide cases in Canada examine the legality of assisted death for terminally ill individuals, very few examine the outcomes for those who provide euthanasia without consent. One such case was that of Robert Latimer. In *R. v. Latimer* (1995), Mr. Latimer was charged with the murder of his 12-year-old daughter who suffered from cystic fibrosis. Tracy was mentally and physically handicapped and was believed by Mr. Latimer to be suffering. In response, he placed his daughter in the cab of his truck, which he filled with carbon monoxide (*R. v. Latimer*, 1995). According to Lemmens and Dickens (2001), the case went to court twice. The first time, Mr. Latimer was charged with first-degree murder carrying a sentence of life in prison with no chance of parole for 10 years. The case was appealed due to jury tampering and resulted in a second hearing, which found Mr. Latimer guilty of murder in the second degree (Lemmens & Dickens, 2001). This case placed the act of nonvoluntary euthanasia in the public spotlight. In addition, Latimer's case gave supporters of assisted death a reason to fight for legalization and opponents an example of the potential slippery slope (Henderson, 2008).

Summary. The debate that currently exists in Canada is similar to the debate that existed in the US 18 years ago. Court cases such as that of Sue Rodriguez (*Rodriguez v. British Columbia*, 1993) and Robert Latimer (*R. v. Latimer*, 2001) have brought the issue of physician-assisted death to public attention and have culminated in the passing of Bill

52 (2014) in Québec and the reexamination of the Gloria Taylor (*Carter v. Canada*, 2012) case by the Supreme Court. Like Oregon in 1997, the public and the provinces must fight the federal government in order to further determine the legality of active euthanasia and physician-assisted suicide as a healthcare issue. Canada has the potential to become like the Benelux countries, legalizing the practice of voluntary active euthanasia and physician-assisted suicide for terminally ill individuals.

Perceptions on Assisted Death

Most of the research solicited on people's perceptions of assisted death is based on questionnaires that ask people to indicate their level of agreement on statements describing this controversial practice. Despite success in describing the perceptions of Canadians on assisted death, questions have been raised regarding the validity of these measures (Marcoux et al., 2007). Specifically, researchers have suggested that the wording of the questions influences participant responses on questionnaires surrounding assisted death. For example, Gamliel's (2013) research found that questions phrased in a more positive way elicit more positive responses, just as questions phrased with a negative slant elicit more negative responses. In addition, Marcoux et al. (2007) found that acceptance of assisted death in surveyed individuals is tied to their knowledge of the practice. Therefore, questions that do not explicitly define the end-of-life practice being examined are more likely to show results that do not accurately reflect the opinions of the individuals being studied (Marcoux et al., 2007). Overall, research studying people's perceptions on assisted death should be interpreted with caution, as the data may reflect biased questioning.

Public. Several factors have been found to influence public opinion with regard to the legalization of assisted death. The strongest factor is a person's level of religious belief. The greater people's faith in their religious beliefs, the more likely they are to disagree with the practice of active euthanasia (Emanuel, 2002; Givens & Mitchell, 2009; Moulton et al., 2006; Wilson et al., 2013). In a study conducted by D. M. Wilson et al. (2013), the relationship between a person's level of religiosity ($n = 1,203$ adults) and their beliefs on active euthanasia was confirmed ($p \leq 0.001$), with those attending religious service tending to be the most opposed to the practice. It is not just the level of religious belief that is important, but also the level at which a person believes in the support of their religious institution. Givens and Mitchell (2009) found that people who have faith in the helpfulness of their religion at the end of their lives (i.e., 56% of the 786 total respondents) were less likely to support active euthanasia as a practice. With recent trends suggesting that religions are becoming more liberal (Moulton et al., 2006), active euthanasia and other forms of assisted death may find more support in the future.

In addition to religion, several other factors have also been found to influence the public's opinion on assisted death. Older adults appear to be less likely than their younger counterparts to want assistance with dying at end-of-life based on a survey of 129 older adults over the age of 60 (Catt et al., 2005). In addition, adults with concerns about the emotional (64% of total respondents) and economic (65% of total respondents) burdens of being terminally ill appear unlikely to support assisted death (Givens & Mitchell, 2009). According to D. M. Wilson et al. (2013), people may be more likely to support active euthanasia if they have experience with the euthanization of a pet ($p \leq 0.001$), the creation of an advance directive ($p = 0.023$), or the treatment decision

of a terminally ill family or friend ($p = 0.014$). According to a quantitative survey of 570 adults, hospice knowledge and death anxiety appear unrelated to a person's support of active euthanasia and physician-assisted suicide (Catt et al., 2005).

A recent Angus Reid Global (2010) public opinion poll revealed that 67% of adult Canadians support active euthanasia. The most support came from Québec and British Columbia with 77% and 75%, respectively, agreeing with the practice. In Alberta, considered the most conservative of the Canadian provinces, nearly 72% of 1,203 people studied were in support of the legalization of active euthanasia (Wilson et al., 2013). Based on these results, one can infer that the majority of Canadians support the legalization of assisted death. However, the majority of Canadians are not terminally ill and suffering in the last years of life.

Patients. Most of the research regarding patients' perceptions on assisted death examined factors that increase the likelihood of a terminally ill patient supporting the practice. Very little research has been dedicated to examining the level of agreement that these patients have, as a population, toward active euthanasia and physician-assisted suicide. Research has suggested that patients' rate of agreement is similar to that of the public (Emanuel, 2002), because the public is generally more empathetic toward the terminally ill than any other population (Yun et al., 2011). Individuals with a cancer diagnosis have been observed to be the most supportive of assisted death (Emanuel, 2002). In a study of 87 relatives of individuals receiving assisted death in the Netherlands, Georges et al. (2007) found that 85% of the terminally ill individuals had cancer and 74% had no hope for recovery. In addition, a qualitative interview of 28 cancer patients found that most appear to have no appreciation of the negative effects that

ending their life would have on other people (Elliott & Olver, 2008). Many terminally ill patients seem to feel ambiguous about the legalization of assisted death itself. Karlsson et al. (2012), through interviewing 66 terminal cancer patients, found that on one hand patients may feel increased autonomy and empowerment through being able to control their own death, while on the other they may feel less autonomy due to the increased power that healthcare professionals would hold over them. This same ambiguity comes across in persons with disabilities who, when interviewed, support active euthanasia but fear they might be discriminated against if legalized (Fadem et al., 2003). This concern may affect the level of support that those with disabilities and terminal illness have for active euthanasia and physician-assisted suicide.

When it comes to the support of assisted death, the most common factor connected to the perceptions of, and likeliness of requests from, the terminally ill appears to be depression. According to van der Lee et al. (2005), whose research involved interviewing and surveying 138 cancer patients, requests for euthanasia are 4.1 times higher in patients who are experiencing a depressed mood. In addition, Johansen, Hølen, Kaasa, Loge, and Materstvedt (2005) found that feelings of current pain, while important, are not a significant factor in determining whether a terminally ill patient would support or request active euthanasia. Through conducting semistructured interviews of 18 terminal cancer patients, Johansen et al. (2005) identified the fear of future pain as being an important part of requesting active euthanasia. An examination of the literature by the New York State Task Force on Life and the Law (1994) identified similar factors as contributing to likelihood of depression for a terminally ill individual. The factor of feeling like a burden on their loved ones is related to the development of psychological

($r = 0.35$ – 0.39) and existential problems ($r = 0.45$ – 0.49) leading to depression in 69 advanced cancer patients (Wilson et al., 2005). When patients are treated for their depression with psychotherapy and antidepressants, many, according to Winograd (2012), withdraw their requests for ending their life. While Winograd did not directly collect data, this conclusion can be supported by the high rates of depression in people who request assistance in dying. It is likely that those with depression could receive treatment for their condition and potentially feel more positive about continuing to live. This is supported by the research of Marcoux, Onwuteaka-Philipsen, Jansen-van der Weide, and van der Wal (2005), who found that individuals who changed their mind were reported as having better mental health than those who were refused for assistance in dying ($n = 6,596$ general practitioners in the Netherlands). As depression appears to be a significant risk factor in requests for assisted death, health professionals should be advised to recognize these symptoms before any action is taken on a terminally ill patient.

In Canada, there is very little research on the perceptions of terminally ill individuals surrounding assisted death. K. G. Wilson et al. (2007) found that 62.8% of cancer patients studied ($n = 69$) would support the legalization of active euthanasia. Of these persons, 39.8% would consider making a future request and 5.8% would request the practice right away (Wilson et al., 2007). More research needs to be conducted in this area in order to determine further the extent to which terminally ill individuals support the legalization of assisted death.

Physicians. Similar to terminally ill individuals, very little research has been conducted on the perceptions of physicians toward the practice of active euthanasia and

physician-assisted suicide (Schüklenk et al., 2011). In a recent Canadian Medical Association vote, only 34% of physicians (out of 287 surveyed) agreed to open up a discussion on the legalization of assisted death in Canada (Eggertson, 2013). Opponents argued that physicians cannot concern themselves with assisted death until they better understand palliative care (Eggertson, 2013). In addition, based on the results from a large quantitative study involving 318 internal medicine residents, new physicians appear to be uninterested in learning more about the issue (Schroder, Heyland, Jiang, Rocker, & Dodek, 2009).

Much like the public and terminally ill, the opinions of medical professionals are affected by several factors. One such factor is the specialization of the physician. According to Emanuel (2002), who reviewed the literature on physicians and assisted death, surgical oncologists, psychiatrists, obstetricians, and gynaecologists appear to be more supportive of assisted death than internists and medical oncologists. In addition, general practitioners are considered to be the most supportive specialization (Emanuel, 2002). According to Levy et al. (2013), who surveyed 103 physicians from Israel using vignettes, female physicians ($n = 42$) appear to be more conservative than male physicians ($n = 59$) and are also less supportive of active euthanasia and physician-assisted suicide. Religion also has an effect, with more religious physicians seeming less supportive of the practice. This is based on the research of Parpa et al. (2010), who found that approximately 60% of physicians agreed with the teachings of their church and 47% of these individuals agreed with the legalization of active euthanasia. Parpa et al. suspected that these teachings, which are primarily Greek Orthodox, were part of the

reason for the reduced support. Under this faith active euthanasia is viewed as an act of murder.

There are many reasons that physicians do not support the legalization of active euthanasia and physician-assisted suicide. Assisted death is in violation of several principles within the Canadian Medical Association (2004) *Code of Ethics*. These principles pertain to the respect for a patient's independence and well-being, a physician's responsibility to society, and the physician's respect for his or her own independence. In addition to these ethical principles, medical professionals tend to fear that a slippery slope may result in requests for assisted death from individuals who are not suffering from a terminal illness (Canadian Medical Association, 2007). People with mental illness or nonthreatening disabilities, for example, may begin to request active euthanasia or physician-assisted death if it became legalized. Tulloch (2005), in describing the slippery slope argument, suggested that physicians around the world believe that they are able to sufficiently manage terminal illness through comprehensive medical care. This may make assisted death unnecessary for terminally ill Canadians. In addition, Ebrahimi (2012), in her outline of the arguments for and against assisted death around the world, suggested physicians seemed concerned about their relationship with the patient; they feared that the trust and confidence that exists within this relationship would be destroyed by assisted death.

Psychologists. Galbraith and Dobson (2000) conducted a review of the literature and suggested, with the rise in health psychology, that psychologists are increasingly becoming involved with patients who are suffering from a terminal medical condition. Psychologists can be part of interdisciplinary teams, which act to support dying

individuals toward the end of their lives. Canadian psychologists seem to be ignored in the debate on the legalization of assisted death (Galbraith & Dobson, 2000). As a result, very little information about their opinions is known. Therefore, all conclusions made in this section are speculative and based on the arguments proposed by previous authors. More research needs to be conducted in this area in order to provide current evidence of the role of psychologists in assisted death and hospitals.

In all cases of legal active euthanasia and physician-assisted suicide around the world, competency is a key factor. According to the opinion of Niederjohn and Rogers (2009), psychologists are the most qualified health professionals to determine a patient's competency due to their training in assessment. Additionally, mental health factors (e.g., depression) are considered by the authors to be heavily involved in a person's end-of-life decisions (Niederjohn & Rogers, 2009). Galbraith and Dobson (2000) argued that psychologists seem to be the professionals with the most knowledge and practical experience to work with conditions in such a vulnerable population (no data collected). Hadjistavropoulos (1996) suggested that with more psychologists working in healthcare settings, there is also an increased likelihood that they will work with a terminally ill individual and his or her family. Through an effective psychotherapy relationship, rather than a physician–patient relationship, patients can fully explore their end-of-life options as well as their feelings free of external pressure (Winograd, 2012). With the projected number of seniors in Canada expected to reach 10.9 million by 2036 (Statistics Canada, 2010) and the rate of mortality from chronic illness expected to increase by 14% per year (Elmslie, 2014), psychologists will likely be in greater contact with those who are terminally ill. It is, therefore, essential that psychologists' perceptions of euthanasia be

used to inform policy such that psychologists may be able to provide best practice to the increasing number of individuals potentially in this situation.

Code of ethics. Best practice for psychologists, regardless of the client population, are grounded in the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000). This code is structured according to four differentially weighted principles, which outline ethical practice in most situations. While the Canadian Psychological Association's *Code of Ethics* does not specifically address the issue of assisted death, it does provide a foundation to understanding the complexity of the debate for psychologists.

Principle I: Respect for the dignity of persons. According to the Canadian Psychological Association (2000) *Code of Ethics*, psychologists must respect the autonomy of their clients to make their own choices and validate their own self-worth. Principle I is very important to the discussion on assisted death because it requires psychologists to report behaviours if a client wishes to harm themselves or others (Canadian Psychological Association, 2000). This principle can conflict with Principle II, as discussed in the following subsection.

Principle II: Responsible caring. Under this principle of the Canadian Psychological Association (2000), a psychologist is not to cause harm (Standard II.2) or aid in activities that would lead to serious harm (Standard II.38). This principle often conflicts with Principle I because assisted death, an act of self-determination, is considered by many to be harmful to the individual (Hadjistavropoulos, 1996). However, the question is to what extent harm is being done on the individual requesting assistance in dying. One must decide whether it is more harmful to allow terminally ill individuals

to die and end their suffering or to keep them alive against their will (Hadjistavropoulos, 1996).

An additional area of concern within Principle II of the Canadian Psychological Association's (2000) *Code of Ethics* is competence. Psychologists must only practice professional activities in which they are competent and able to act in the client's best interests (Standard II.6). Currently, there is no professional certification or standards to provide competency for working with terminally ill individuals (Werth et al., 2009) and those requesting assistance in dying. Therefore, many psychologists, following Standard II.6, may not feel competent practicing with this population. They may feel they lack the skills that would allow them to act in the client's best interests. In order to remedy this concern, training programs may need to be established in order to familiarize psychologists with the issues and concerns surrounding terminal illness and assisted death. However, some have suggested that all that is necessary from psychologists is an openness and ability to reflect on their own feelings (Werth et al., 2009). This is representative of Standard II.10, which requires self-awareness of how personal concerns may influence their interactions with others (Canadian Psychological Association, 2000).

Principle III: Integrity in relationships. Under Principle III, psychologists are required to be objective, straightforward, and active in avoiding conflicts of interest (Canadian Psychological Association, 2000). Under Standard III.10, psychologists must be aware of their own perceptions and biases in order to be as objective as possible with their clients (Canadian Psychological Association, 2000). From an applied perspective, the Canadian Psychological Association requires psychologists to be aware of their own biases surrounding assisted death. In doing so, psychologists allow themselves to be

objective by not having their personal beliefs undermine the therapeutic work being done with clients.

Principle IV: Responsibility to society. Psychologists have a social contract with the general population which stipulates that, in exchange for the ability to self-govern, psychologists must put the welfare of society above their own (Canadian Psychological Association, 2000). In doing this psychologists must act in a way that advocates for the betterment of their clients and society in general. It is the opinion of the researcher that this is especially important in working with the terminally ill, as these individuals may request assistance in dying, and it is the responsibility of the psychologist to act on the patient's behalf to create the social change that would make this request possible. In addition, it is the responsibility of the psychologist to promote the welfare of individuals within a society (Canadian Psychological Association, 2000). Therefore, in addition for advocating for clients, a psychologist may have to consider the impact that the legalization of assisted death may have for everyone else. Psychologists must consider arguments such as the slippery slope in determining whether the practice of assisted death is something to advocate in Canadian society.

Best practice as a psychologist. With more psychologists working in healthcare settings, it seems essential that psychologists rely on the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000) for best practice in working with terminally ill individuals. However, with the ambiguity just demonstrated, it is difficult to know how to proceed if a terminally ill individual discloses a wish for assistance in dying. According to Winograd (2012), a psychologist in this situation must proceed with caution, because detailed discussions about euthanasia may be considered

illegal and unethical since it violates Canada's Criminal Code (1985). Until legislation is developed in accordance with the Supreme Court of Canada's ruling in *Carter v. Canada* (2015), psychologists perhaps should begin by focusing their attention on resolving or reducing any mental or physical suffering (Winograd, 2012).

While not discussing assisted death with a client seems appropriate as long as legislation does not exist, it might not be an appropriate course of action when active euthanasia or physician-assisted suicide is legalized, at which point the best practice may involve further direct discussions surrounding the controversial practice. This is similar to best practice involving suicide (Meichenbaum, 2005), an area that has not been studied in relation to perceptions of assisted death. More research needs to be conducted on assisted death with regard to Canadian psychologists. An understanding of their perspective would enable researchers, the public, and policy makers to appreciate euthanasia from a new perspective.

Summary. Psychologists are important to the debate on active euthanasia and physician-assisted suicide because of their potential for experience with terminally ill individuals, their ability to assess competence, and their understanding of the related mental health factors. Despite this recognized knowledge, the researcher discovered a gap in the literature examining the perceptions of this population on assisted death. Previous studies have examined perceptions in other populations and found that the majority of Canadians, excluding physicians, show support for active euthanasia and physician-assisted suicide. In addition, factors such as religious conviction and province of residence have been shown to influence these beliefs. In order to inform the literature and public policy, research needs to be conducted on the perceptions of psychologists on

assisted death. Researchers and policy makers need to understand how psychologists perceive assistance in dying and what factors influence these beliefs.

Chapter Summary

After reviewing the literature, it is apparent that assisted death is a complex and contentious issue. Many questions have arisen, none of which have simple right or wrong answers. Instead, people and countries do the best they can to ensure that the rights of the terminally ill, disabled, general public, and medical professionals are protected. In some countries, such as the Benelux countries, these issues are closer to being resolved. However, in countries like Canada, new developments emerge frequently that challenge the current views of terminal illness and death. Psychologists, as a profession, have generally been disregarded in the debate on active euthanasia and physician-assisted suicide. However, they can provide much insight and practical experience to an issue that is abstract and difficult for many to conceptualize. Psychologists need to be involved in the debate on assisted death. The current state of their knowledge and beliefs need to be known. This process has begun with the research conducted in this thesis.

The next chapter details the methodology by which the research questions were addressed. This leads into a presentation of the results, which are analyzed in a later chapter.

Chapter 4: Methods

This chapter builds off of the foundation provided by the current literature discussed in the previous chapter. The participants, procedure, survey instrument, and data analysis methods all reflect the work outlined in the previous chapter. This work was extended to address the research questions outlined in Chapter 2.

Participants

Participants were recruited using three methods of advertisement. First, Canadian Registered Psychologists were targeted using advertisements on Facebook (2015); these were tailored such that only those who meet the study criteria would be able to view the advertisement and access the survey (see Appendix A for the advertisement). The literature indicated that the majority of psychologists use some form of social media platform (Anderson & Guyton, 2013; Taylor, McMinn, Bufford, & Chang, 2010) in their personal lives. Therefore, advertising through this medium was believed by the researcher to be an effective way of accessing large numbers of Canadian psychologists.

Second, the Canadian Psychological Association (2014b) *Recruit Research Participants Portal* (R²P²) was used to invite participants. This portal provides access to all 6,841 of its members (Canadian Psychological Association, 2013) for the purposes of research. In addition to R²P², participants were recruited using the Canadian Psychological Association (2014a) newsletter *CPA News*; this newsletter electronically publishes information about all of the studies conducted through R²P² (see Appendix B for the advertisement). Only members of the Canadian Psychological Association have access to this portal and receive this newsletter.

Third, provincial and territorial psychological associations were approached due to a low sample size resulting from the first two recruitment methods. These associations were able to provide access to registered psychologists through online advertisements, email contact, and paper newsletters. In the event that a psychological association did not exist, the provincial or territorial college was approached (see Appendix B for the advertisement). This method allowed the majority of registered psychologists to be accessed, pending permission from the colleges or psychological associations.

While the Canadian Psychological Association has a wide variety of members, this study only recruited a subset for the purposes of answering the research questions described in Chapter 1. The participants who qualified to be involved in this study were a convenience sample of the total population and represented the population of registered psychologists who are currently working across Canada. For the desired statistics to be used, a minimum sample size of 100 participants was required (see Concoto, Peduzzi, Holford, & Feinstein, 1995). In order to obtain this sample, the response rate needed to be approximately 2.3%. This was believed to be achievable by the researcher, even with response rates being recorded as low as 10–20% for online surveys (Sauermann & Roach, 2013).

Inclusion and Exclusion Criteria

In order to be included in this study, participants had to meet certain criteria. The individuals needed to be registered psychologists in Canada at the time of the study. Participants could not be honorary members of the Canadian Psychological Association, student members, provisional psychologists, or members who were not certified as

psychologists in their province. In total, 4,288 members qualified for participation in this study as of June 2013 (Canadian Psychological Association, 2013).

The Survey on Death and Dying

In order to address the research questions, participants responded to an online survey using the survey development software, SurveyMonkey (2015); this survey, created by the researcher, contained 32 questions and took a maximum of 20 minutes to complete (see Appendix C for a copy of the survey). The survey was available to participants for a period of 2 months and was accessible through R²P² (Canadian Psychological Association, 2014b) and Facebook (2015) advertisements as well as through consenting psychological associations and colleges. Multiple entries were disallowed so participants could only provide one completed survey per computer. In addition, the automatic collection of IP addresses was disabled for the purposes of this survey.

Section I of this survey was comprised of screening information and contained one item that served to evaluate whether people qualified for participation in this research. The question asked whether a person was a registered psychologist located within Canada. If the answer was “no,” the individual received a message to thank him or her for expressing interest in the study and then informed the person that he or she did not meet the study requirements. If the individual did qualify, the participant was able to proceed with the remainder of the survey.

Once the person was deemed eligible for the study, the participant proceeded to Section II, which asked the individual to enter demographic information pertaining to the participant’s gender, religious beliefs, province of practice, specialty, workplace, and

experience with the terminally ill and suicidal. These were all demographic factors reviewed in Chapter 2 and were found to be significant in other surveyed populations. The purpose of these questions was to address the second research question. Further, these questions were placed at the beginning of the survey in order to ensure that a) participants were eased into a survey on a potentially emotional subject, and b) demographic information was collected from participants regardless of when, or if, they dropped out.

Section III of the survey evaluated psychologists' perceptions toward the practice of assisted death. The first question examined how participants felt about individuals choosing to shorten their lives when the costs of living outweighed the benefits (see Appendix C). The second question, modified from D. M. Wilson et al.'s (2013) article, examined how participants felt regarding the client's right to receive physician-assisted death. The original question, proposed by D. M. Wilson et al. (2013), left room for interpretation such that participants may not have, for example, been clear on whether the terminally ill individual was able to consent to his or her own death. In this survey, the question was modified to limit the amount of interpretation through providing details about competency as well as using the word "death" over "suicide" In addition, the term death was used to more openly address several forms of assisted death (i.e., physician-assisted suicide and voluntary active euthanasia by a physician). Overall, both research questions evaluated a participant's perceptions of assisted death, but each examined a different aspect of the practice: the choice and the request. Participants provided answers that reflected their personal and professional opinions, with each being rated as "yes, I believe every competent adult should have this right; yes, but it should be allowed only in

certain cases or situations; or no [I do not believe anyone should have this right]” (Wilson et al., 2013, p. 202). This section of the survey specifically addressed the first research question.

Section IV of the survey examined the fundamental knowledge that psychologists possessed surrounding the practice of euthanasia; this knowledge was assessed using a series of small scenarios adapted from Marcoux et al.’s (2007) works, which provided descriptions of different end-of-life practices. The adaptations made to the original question did not change the content of the question. Instead, the question was phrased in such a way that it was uniquely relevant to the current thesis research as well as Canadian registered psychologists. The scenarios covered three forms of assisted death: voluntary active euthanasia, voluntary passive euthanasia, and physician-assisted suicide.

Participants were asked to determine whether or not the scenario constituted a typical form of euthanasia (i.e., because euthanasia was believed by the researcher to be a familiar term to the lay public). If participants were unsure, they were provided with a “not sure” option, in order to reduce the pressure to make an uninformed choice.

Participants’ responses to these questions enabled the researcher to determine whether psychologists knew what euthanasia was (i.e., the active and passive variants) and how it differed from other practices (i.e., physician-assisted suicide). This allowed the researcher to address the third research question. Knowledge of assisted death was not assessed beyond the scope of differentiating practices categorized under assisted death.

Section V evaluated the competency of psychologists with regard to terminal illness and requests for assistance in dying. All of the statements included in this section were rated according to a five-point Likert scale ranging from strongly disagree to

strongly agree. This served to provide information to address the fourth research question, which was described in detail in Chapter 2. The first statement examined how competent psychologists perceived themselves when working with the terminally ill requesting assistance in dying. Competency, as defined in Chapter 1, referred to the psychologist's level of training. Work referred to the psychologist's assessment of a patient's competency when he or she requests assistance in dying. This definition of work was carried over into the next statement, which examined how confident psychologists were in their abilities to work with terminally ill individuals who request assistance in dying. The final statement examined whether psychologists believed they should receive training in the end-of-life issues. This would include training in assessment, decision making, and working with the medical system.

In the final section, Section VI, psychologists were presented with two vignettes that aimed to assess the participant's professional and personal perceptions of assisted death. More detail on these questions is provided later in this section. In the first vignette, adapted from Levy et al. (2013), a man with inoperable stomach cancer requested support from his psychologist to his doctor about receiving assistance in ending his life. The psychologist, who was not part of Levy et al.'s original situation, provided counselling to this individual. The scenario was presented in the form of case notes and differed from Levy et al.'s work in that it did not use medical jargon. In this way the research question was adapted for the benefit of the psychologist participant.

The second vignette was based off of an incident that was brought to the Supreme Court in the Netherlands. A woman suffering from lifelong severe depression was provided with active euthanasia by her psychiatrist after all other treatments had failed

(Gevers & Legemaate, 1998). In order to make this vignette more difficult for psychologists to agree, the symptoms of the woman were made more severe. In addition, the psychologist was only providing counselling in the scenario and was not responsible for providing assistance in dying. The purpose of this second vignette was to explore how psychologists felt about instances of assisted death that were based on a mental, rather than terminal, illness. In a manner similar to the first vignette, this second scenario was presented in the form of case notes for the ease of the psychologist participant.

In accordance with the work of Levy et al. (2013), each vignette included five statements, which participants rated from strongly disagree to strongly agree. The first statement, adapted from Levy et al., rated the participant's level of agreement for supporting the client's request as a professional psychologist. The second statement was an extension of the first in that it examined whether a psychologist was able to stay neutral, as a registered psychologist, when discussing assisted death with a client. The third statement, adapted from Levy et al., allowed the participant to take the client role and asked whether the participant would ask for assistance in dying were he or she in the client's position. This statement was intended to evaluate participant's personal perceptions towards the practice. The fourth and fifth statements examined how the participant's opinions would change if the person were younger and had a chance of meaningful improvement (see Appendix C). This was an indicator of professional perceptions; participants were encouraged to respond as registered psychologists.

Procedure

The following section outlines the procedure used to conduct the thesis research. For further information on the survey instrument or the participant recruitment procedures, see the earlier sections of this chapter.

Ethical clearance. Before beginning the study, the proposed research was evaluated by an ethics board at the University of Lethbridge (see Appendix D). Upon approval, the survey was opened and the study was advertised.

Informal testing. To ensure that the survey was understandable, appeared efficient, and did not consume a lot of the participants' time, the survey was pilot tested with 10 Master of Education (Counselling Psychology) students at various stages of the survey development. None of the informal data were recorded, as pilot participants were asked to provide artificial results. This was to protect the privacy of those piloting the survey. The only information collected were their comments on the survey as well as the time it took them to complete. Registered psychologists were not part of the pilot study in order to avoid contaminating the sample.

Recruitment. Advertisements were posted in May of 2014 on R²P² (Canadian Psychological Association, 2014b), *CPA News* (Canadian Psychological Association, 2014a), and Facebook (2015) as well as distributed by consenting provincial and territorial psychological associations. In this posting information was provided to the participants about the study itself, eligibility criteria, expectations of participants, and the length of time for the study. A link was provided that directed participants to the research survey.

Consent. When participants first accessed the Survey on Death and Dying (see Appendix C), they were provided with a consent form (see Appendix E). This was the first page of the survey and presented information to the participants about what they could expect by electing to take part in the study. Included in this information were the risks and benefits of participant confidentiality and anonymity, withdrawing from the study, as well as contact information for the researcher. Any participants who wished to receive feedback regarding the results of the inquiry were advised to email the thesis researcher. Upon completion of the study, individuals who contacted the researcher were sent a summary of the thesis research outcomes.

Data collection, storage, and destruction. Once the survey was closed in July of 2014, no further participant data were collected. Information collected on SurveyMonkey (2015) was downloaded into SPSS and analyzed in order to determine the results of the study. This information was saved exclusively on an encrypted flash drive and stored in a locked filing cabinet only accessible to the researcher, her supervisor and committee members, and a statistician. As the study is now complete, the flash drive will be kept secure in the same location for 7 years, at which point the flash drive will be cleared and destroyed.

For those participants who requested outcomes, their names were placed on a hard copy list that was stored separate from the survey in a separate filing cabinet that was only accessible to the researcher. Once the study was complete, the participants were individually emailed an overview of the study results. Their email addresses will be saved for a period of 7 years before being incinerated by the researcher.

Analysis

Once collected, the data were analyzed in SPSS in order to answer the research questions (see Chapter 1). This was done through the use of descriptive and nonparametric statistics, which are detailed in the following sections of this chapter.

Descriptive statistics. For each of the research questions, descriptive statistics were used to provide a profile of the general population. This was used to create the initial results that could be interpreted using nonparametric statistics. Several descriptive statistics were used.

Frequency distributions were created to examine the number of times a question was answered in a certain way and what percentage of the sample this answer represented. As not all of the data collected were continuous or rank scored, frequency distributions served to provide information about the categorical responses collected (Gall, Gall, & Borg, 2007). The data provided the frequency, or regularity of a categorical answer occurring, and the percentage that this frequency represented from the total sample. For example, frequency distributions were used to describe the specializations of psychologists participating in the study. These distributions were also used to describe participant responses provided on the Likert-scale questions regarding assisted death.

Measures of central tendency such as the mean and median were used to describe the average numerical response of the participants (e.g., the average age of psychologists who completed the survey instrument). The mean was reported to present the average scores of participants for each individual question. The median was reported alongside the mean in order to demonstrate any skewing that could occur in the data. Skewing

occurs when the mean is pulled from the centre of the scores toward the more extreme data points (Gall et al., 2007). In these situations the median is a better descriptor of the average and the mean is a better descriptor of the shape of the data set.

Measures of variability were used in conjunction with measures of central tendency in order to describe the distribution of the scores (Gall et al., 2007). These measures provided information regarding how the scores were clustered and whether they were close together or far apart around the mean or median. In the case of this research, the standard deviation was reported. The standard deviation is considered stable across populations and is able to be used to compute further statistics (Gall et al., 2007). Overall, the descriptive statistics in this study were used to describe the responses of the participants.

Nonparametric statistics. In order to evaluate the relationships present within the research questions, nonparametric statistics were used. In this study two forms of nonparametric statistics were used: the chi-square test and univariate analysis (i.e., Kendall's correlation and Spearman's correlation). Only nonparametric statistics that have a cell count above five were reported as cell counts below five violate the assumptions of these tests (Concato, Peduzzi, Hudford, & Feinstein, 1995).

The chi-square test traditionally uses frequency to determine if there is a significant difference between categories (Gall et al., 2007). With regards to the first research question, this test was used to create a cross-tabulation that compared the distribution of psychologists' perceptions regarding physician-assisted death with the rule of thirds. By comparing the two against each other (i.e., the actual distribution versus the hypothesized distribution), it was determined whether there was a difference between

these two distributions. The third research question utilized the same chi-square test in order to determine whether the knowledge of psychologists in this thesis was related to the results found by Marcoux et al. (2007). In this chi-square comparison, two sets of actual data were compared.

Univariate analysis was used to examine the relationship between the demographic variables and psychologist perceptions. Specifically this analysis addressed the second research question by elaborating on the descriptive statistics that detail the characteristics of the population. Originally, a nonparametric logistic regression was going to be used to address this question; however, the skewing of the data and low sample size made this statistical analysis unusable (see Concoto et al., 1995). As a result, Kendall's tau-b rank correlation coefficient and Spearman's rho were used.

Kendall's correlation is nonparametric univariate analysis that measures the association between ordinal variables that produce tied ranks (Hanna & Dempster, 2012). For example, the responses to a Likert-scale style question. The majority of responses relating to psychologist perceptions produce tied ranks; as a result, Kendall's tau-b rank correlation coefficient was used. Kendall's correlation was used to analyze the relationship between psychologists' perceptions and gender, province of practice, professional specialty, workplace, religious beliefs, personal and professional experience with terminal illness, and feelings of competence working with a terminally ill individual.

Spearman's correlation is a nonparametric univariate analysis that measures the relationship between ordinal or interval/ratio variables (Hanna & Dempster, 2012). For example, this analysis was used to measure the relationship between age (i.e., a ratio value) and perceptions on assisted death for terminal illness (i.e., a categorical value).

Spearman's rho was used to examine the association between psychologist perceptions and the variables of age, length of time as a registered psychologist, number of terminally ill clients, and number of suicidal clients.

Overall, nonparametric statistics were used to answer the first, second, and fourth research questions. This information provided a more detailed picture of the relationship between variables in the study population.

Reliability. As this research involved the implementation of a researcher-created survey, reliability was measured. This determined whether the survey instrument was able to consistently measure the same variables. Reliability was assessed on two levels, as a whole test and as individual sections of the tests, in which the necessary requirements are met. For example, the demographic information section of the survey was not assessed for reliability. The reason for this was because this section was intentionally not measuring the construct of perceptions surrounding assisted death. The information gathered from this section, as well as having more than one question, were the criteria for inclusion in the reliability analysis. Internal consistency, specifically Cronbach's alpha, was used to determine whether there was correlation between items on the survey. This demonstrated whether the whole test was measuring the same construct. The Spearman-Brown prophecy coefficient was used to measure the split-half correlation. This statistic predicted the reliability of the survey on the basis of half-test correlations.

Summary

In order to address the research questions, participants were asked to complete a short survey on their perceptions, knowledge, and agreement toward assisted death.

These participants were recruited from Facebook (2015), R²P² (Canadian Psychological Association, 2014b), and *CPA News* (Canadian Psychological Association, 2014a) as well as consenting provincial and territorial psychological associations. Upon completion of the survey, the results were downloaded into SPSS and analyzed using descriptive and nonparametric statistics. In addition, reliability for the survey was determined. Overall, these methods provided the basis of this thesis research and allowed the researcher to rectify a gap in the literature.

Chapter 5: Results

In order to address the four research questions, psychologists across the country were given the opportunity to participate in this thesis survey. A total of 97 individuals participated, with all but four having listed themselves as being registered psychologists practicing in Canada. One did not respond to any of the survey questions and was not included in the analysis. The first section of this chapter provides demographic information for the remaining 92 individuals as well as information on the reliability of the survey instrument. The second section outlines the results of each research question. Variability in the number of participants occurs across this chapter as a result of the intermittent patterns of responding displayed by respondents. When not otherwise indicated, it should be assumed that the sample size reflects the total number of participants (i.e., $n = 92$).

Instrument Reliability

The researcher-created survey was evaluated for its ability to measure the specific variables being studied (i.e., perception, knowledge, and competency). This was done using Cronbach's alpha and the Spearman Brown prophecy coefficient. More information on these tests can be found in the methods section of Chapter 3.

Internal consistency. Of the three scales in the survey instrument, two were found to be highly reliable. The 14-item perception scale, which consisted of the vignettes and the questions regarding the right to refuse treatment and right to receive physician-assisted death, had a Cronbach's alpha of 0.90. This indicates that this scale strong in its measurement of one construct, which was believed by the researcher to reflect perceptions of assisted death. The two-item competency scale, which consisted of

items examining confidence and training in assessing competency, had a Cronbach's alpha of 0.95. One item had to be removed from this reliability analysis (i.e., "I think psychologists should receive training in the area of end-of-life issues, such as assessment, decision making, and working with the medical system") due to its low correlation with the full scale. The three-item knowledge scale, which was discussed as part of the third research question, was the only scale found to have low reliability ($\alpha = 0.37$).

Split-half reliability. The one item omitted from the internal consistency analysis was included in the analysis of split-half reliability. As a result, the Spearman Brown prophecy coefficient for the 20-item instrument was found to be 0.53. This is considered a low reliability score and can be improved upon in later research by increasing the length of the instrument and reducing sources of ambiguity within the individual items.

Participant Information

Age and gender. The age of the qualifying 92 participants ranged from 26 to 78 years old. The mean of this distribution was 50.63 years and the standard deviation was 12.3. With regard to gender, the majority of participants were female, with males comprising only 28% ($n = 26$) of the sample. Females, on the other hand, comprised 78% of the sample ($n = 66$).

Province of residence. The majority of participants indicated residence in the provinces of New Brunswick ($n = 30$; 32.3%), Manitoba ($n = 23$; 24.7%), and Newfoundland and Labrador ($n = 22$; 23.7%). No participants identified themselves as living in Alberta, Northwest Territories, Nova Scotia, Nunavut, Ontario, Québec, Saskatchewan, and Yukon. Table 1 presents a frequency distribution of participants

across all of the provinces. A further discussion of this distribution can be found in the Limitations of the Research section of Chapter 5.

Table 1

Frequency Distribution for Question 4 – Participants' Province of Residence

Province of Residence	<i>F</i>	%
Alberta	0	0
British Columbia	10	10.8
Manitoba	23	24.7
New Brunswick	30	32.3
Newfoundland & Labrador	22	23.7
Northwest Territories	0	0
Nova Scotia	0	0
Nunavut	0	0
Ontario	0	0
Prince Edward Island	6	6.5
Québec	0	0
Saskatchewan	0	0
Yukon	0	0
Total	93	98.0

Note. The total percentage does not add to 100% due to rounding.

Professional specialty. Respondents were given the option of reporting multiple professional specialties. In order of descending frequency, the studied psychologists indicated that they practiced within clinical psychology ($n = 58$; 63.7%), health psychology ($n = 23$; 25.3%), counselling psychology ($n = 21$; 23.1%), school psychology ($n = 18$; 19.8%), child and adolescent psychology ($n = 17$; 18.7%), professor or teaching ($n = 17$; 18.7%), couples and family psychology ($n = 12$; 13.1%), supervision ($n = 11$; 12.1%), research ($n = 10$; 11.0%), group psychology ($n = 7$; 7.7%), forensic psychology ($n = 5$; 5.5%), and organizational psychology ($n = 5$; 5.5%). Several participants

indicated a specialty that was not listed by the researcher. These included rehabilitative psychology ($n = 2$; 2.3%), clinical neuropsychology ($n = 1$; 1.1%), geropsychology ($n = 1$; 1.1%), and developmental psychology ($n = 1$; 1.1%). When all 92 participants were asked to identify the one specialty they most identify with, the majority identified clinical psychology ($n = 41$; 45.1%), school psychology ($n = 13$; 14.3%), and counselling psychology ($n = 12$; 13.1%) as their primary practice. Table 2 provides the distribution of these identified specialties across the sample.

Table 2

Frequency Distribution for Question 5 – Professional Specialties Participants Most Identified With

Specialties	<i>f</i>	%
Clinical Psychology	41	45.1
Counselling Psychology	12	13.1
Forensic Psychology	3	3.3
Child and Adolescent Psychology	9	9.9
School Psychology	13	14.3
Health Psychology	7	7.7
Organizational Psychology	0	0.0
Couples and Family Psychology	0	0.0
Research	0	0.0
Professor or Teaching	3	3.3
Supervision	0	0.0
Group Psychology	0	0.0
Other*	3	3.3
Total	91	100.0

Note. *Other includes developmental psychology, rehabilitative psychology, and clinical neuropsychology.

Location of practice. In addition to being able to select multiple areas of practice, psychologists had the ability to pick multiple workplace locations. The majority of participants indicated working in private practice ($n = 36$; 38.7%), hospital ($n = 21$; 22.6%), and academic ($n = 15$; 16.3%) settings. A total of 16 individuals (15.1%) indicated a location other than those provided. The most common of these locations included community clinics ($n = 7$; 6.6%) and government organizations ($n = 4$; 3.8%). Table 3 reflects the distribution of the participant's primary workplace.

Table 3

Frequency Distribution for Question 7 – Participants' Location of Practice

Location of Practice	<i>F</i>	%
Private Practice	36	39.1
Hospital	21	22.8
Non-Profit Organization	2	2.17
Correctional Facility	4	4.35
Academic Setting	15	16.3
Primary-Secondary Schools	12	13.0
Other*	16	17.4
Total	106	115.12

Note. Participants could select multiple locations of practice. The total percentage does not add to 100% due to the variable being not mutually exclusive. *Other includes clinical neuropsychology, community clinic, government, long-term care, specialized clinic, and private unpaid advocacy work.

Number of years in practice. Participants reported practicing an average of 14.0 years as a registered psychologist with a standard deviation of 10.5 years. The range of this distribution was between zero and 42 years: the zero being hypothesized to indicate that the participant was a newly registered psychologist with less than 1 month of experience. Table 4 provides a frequency distribution of these data.

Table 4

Frequency Distribution for Question 8 – Participants' Number of Years in Practice

Number of Years	<i>F</i>	%
0–4	16	17.6
5–9	23	25.3
10–14	15	16.5
15–19	12	13.2
20–24	8	8.8
25–29	8	8.8
30–34	4	4.4
35+	5	5.5
Total	91	100.1

Note. The total percentage does not add to 100% due to rounding.

Religion and spirituality. When asked to indicate whether or not they were religious or spiritual individuals, 49 of the 91 participants (53.8%) indicated that they considered themselves a religious or spiritual person. These individuals, grouped with the 10 participants (11.0%) who were not sure about their level or religion or spirituality, were asked more specific questions about their beliefs and practice. Table 5 provides the frequency distribution of this information. The remaining 32 participants (35.2%) indicated they did not consider themselves a religious or spiritual person. They, therefore, did not answer the clarifying questions.

Experience with terminal illness. The psychologists studied appear to have more personal than professional experience in supporting individuals with a terminal illness. With regard to personal experience, 52 of the 86 respondents (59.8%) indicated that they had supported a person with a terminal illness in the past. This is in contrast to

the 33 psychologists (37.9%) who reported not having this experience. One individual was not sure whether he or she had supported an individual who was terminally ill.

When asked about their experience professionally supporting an individual with a terminal illness, 36 participants (41.4%) indicated having this experience. This is in contrast to 58.6% of respondents (i.e., 51 individuals) who indicated that they had never professionally supported a terminally ill client. This finding was supported by the number of terminally ill clients on each of the studied psychologist's caseload. On average, participants indicated that approximately 6.2% of their caseload consisted of individuals with a terminal illness. The standard deviation of this distribution was 15.6 and the range was between zero and 90%.

Table 5

Frequency Distribution for Questions 10 to 12 – Participants' Level of Religion and Spirituality

Rating	Guides Moral and Ethical Thinking		Actively Practices		Helps End-of-Life Decisions	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Strongly Agree	8	13.8	13	22.0	14	23.3
Agree	16	27.6	14	23.7	25	41.7
Neither Agree nor Disagree	18	31.0	5	8.5	16	26.7
Disagree	11	19.0	13	22.0	2	3.3
Strongly Disagree	5	8.6	14	23.7	3	5.0
Total	58	100	59	99.9	60	100

Note. The total percentage does not add to 100% due to rounding.

Experience with suicide. The number of suicidal clients that studied psychologists had on their caseload was slightly higher than the number of individuals with terminal illness. Overall, the 86 participants indicated that between zero and 80% of

their caseload consisted of suicidal clients. The mean of this distribution was 15.1% and the standard deviation was 18.8.

Addressing the Research Questions

Research Question 1. The first research question addresses the personal and professional perceptions of registered psychologists on assisted death. In order to respond to this question, two forms of statistical analysis were used: descriptive statistics and a chi-square analysis. More detailed information on the use of these methods can be found in chapter three.

Descriptive statistics. Table 6 presents a frequency distribution of the right to refuse treatment (i.e., passive euthanasia). It was found that professionally, 96.3% ($n = 82$) of participants indicated some level of support for the practice. Professional perceptions, for the remainder of this thesis, refer to the participant's perceptions as registered psychologists. From a personal viewpoint, 93.1% ($n = 80$) of participants indicated some level of support for a refusal of treatment. Personal perceptions refer to the participant's perceptions as a member of the general public.

Table 7 contains a frequency distribution for psychologists' perceptions on the right to receive assistance in dying (i.e., active euthanasia and physician-assisted suicide). Overall, participants appeared to support the practice with 92.9% ($n = 80$) supporting it professionally and 91.7% ($n = 78$) supporting it personally. These numbers are slightly, but not significantly, lower than with the right to refuse treatment (see Table 6). In addition, an increased incidence of conditional acceptance was found for the right to receive assistance in dying. Professionally, 40.5% ($n = 34$) of individuals conditionally supported the practice as compared to the 18.6% ($n = 16$) that conditionally supported the

right to refuse treatment. In the personal domain, this result was also found with 14.0% ($n = 12$) and 34.1% ($n = 29$) conditionally supporting the right to refuse treatment and the right to receive assistance in dying, respectively (see Tables 6 and 7).

Table 6

Frequency Distribution for Question 17 – Participants' Perceptions on the Right to Refuse Medical Treatment

Rating	Professional Opinion		Personal Opinion	
	<i>f</i>	%	<i>f</i>	%
Yes, I believe every competent adult should have this right.	66	76.7	68	79.1
Yes, but I believe it should be allowed only in certain cases and situations.	16	18.6	12	14.0
No, I do not believe anyone should have this right.	4	4.7	6	7.0
Total	86	100	86	100.1

Note. The total percentage does not add to 100% due to rounding.

Table 7

Frequency Distribution for Question 18 – Participants' Perceptions on the Right to Receive Assistance in Dying

Rating	Professional Opinion		Personal Opinion	
	<i>f</i>	%	<i>F</i>	%
Yes, I believe every competent adult should have this right.	44	52.4	49	57.6
Yes, but I believe it should be allowed only in certain cases and situations.	34	40.5	29	34.1
No, I do not believe anyone should have this right.	6	7.1	7	8.2
Total	84	100	85	99.9

Note. The total percentage does not add to 100% due to rounding.

Table 8 provides a frequency distribution of the results from the first vignette.

When asked about specific situations in which a person requests assistance in dying due to terminal illness, 52.5% ($n = 44$) of surveyed psychologists indicated that they would be willing to support an individual's request. In addition, the majority of participants ($n = 66$; 78.6%) indicated they would be able to stay neutral in working with the client. Even in the event that the client was 30 years old, many participants ($n = 39$; 46.4%) seemed to support the practice. However, the majority of studied psychologists disagreed with assistance in dying ($n = 57$; 67.8%) if there was a chance of meaningful improvement. In the event that the participant became the client with mental illness, an equal number of surveyed psychologists agreed to the practice ($n = 35$; 41.7%) or were undecided ($n = 35$; 41.7%).

Table 9 provides a frequency distribution of the results for the second vignette.

When the surveyed psychologists were asked about whether they would support a client requesting assistance in dying for mental illness, 71.1% ($n = 59$) reported that they would not support a client's request. However, 54.2% ($n = 45$) agreed they would be able to stay neutral in this unusual case of assisted death. With regard to the added condition of age, the majority of studied psychologists ($n = 31$; 78.3%) disagreed with the use of assisted death in a 30-year-old client suffering from mental illness. Further, 89.2% of participants ($n = 74$) disagreed with the practice when there was a chance of meaningful improvement in the client's mental health. When asked about assisted death for themselves in the event that they were mentally ill, 45.8% ($n = 38$) of participants were undecided. This is in contrast to the 16.9% ($n = 14$) of studied psychologists studied who agreed that they would ask for assistance in dying if they were mentally ill.

Table 8

Frequency Distribution for Vignette 1 – Individual with a Terminal Illness

Participant's Position	Professionally willing to support the client's request		Professionally able to remain neutral in discussing the request		Would be willing to ask for assistance in dying if they were the client in this scenario, and had been suffering like he has for 3 years.		Professionally willing to support the client's request even if he was 30 years old, instead of 80 years old.		Professionally willing to support the client's request even if there was a chance of meaningful improvement.	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>F</i>	%	<i>f</i>	%
Strongly Agree	10	11.9	14	16.7	14	16.7	8	9.5	1	1.2
Agree	34	40.5	52	61.9	21	25.0	31	36.9	4	4.8
Neither Agree Nor Disagree	22	26.2	12	14.3	35	41.7	24	28.6	22	26.2
Disagree	13	15.5	5	6.0	7	8.3	14	16.7	37	44.0
Strongly Disagree	5	6.0	1	1.2	7	8.3	7	8.3	20	23.8
Total	84	100.1	84	100.1	84	100	84	100	84	100

Note. The total percentage does not add to 100% due to rounding.

Table 9

Frequency Distribution for Vignette 2 – Individual with a Mental Illness

Participant's Position	Professionally willing to support the client's request		Professionally able to remain neutral in discussing the request		Would be willing to ask for assistance in dying if they were the client in this scenario, and had been suffering like he has for 3 years.		Professionally willing to support the client's request even if he was 30 years old, instead of 65 years old.		Professionally willing to support the client's request even if there was a chance of meaningful improvement.	
	<i>f</i>	%	<i>F</i>	%	<i>f</i>	%	<i>F</i>	%	<i>f</i>	%
Strongly Agree	1	1.2	6	7.2	2	2.4	1	1.2	0	0
Agree	8	9.6	39	47.0	12	14.5	1	1.2	2	2.4
Neither Agree Nor Disagree	15	18.1	18	21.7	38	45.8	16	19.3	7	8.4
Disagree	40	48.2	14	16.9	20	24.1	42	50.6	36	43.4
Strongly Disagree	19	22.9	6	7.2	11	13.3	23	27.7	38	45.8
Total	83	100	83	100	83	100.1	83	100	83	100

Summary of findings for the vignettes. Overall, Tables 8 and 9 demonstrate that the psychologists studied were more supportive of assisted death for terminal illness than for mental illness. In addition, participants did not appear to agree with the practice when clients had a chance of meaningful improvement or if the age of the client was reduced. This was regardless of whether an individual with terminal or mental illness was requesting assistance in dying. In both cases of terminal and mental illness, the majority of psychologists studied indicated that they would be able to remain neutral in working with a client to evaluate the benefits and detriments of assisted death. However, when asked about assistance in dying in the event that they were the client, many participants were undecided. More of the individuals studied disagreed with assistance in dying for themselves in the event that they were suffering from a mental illness. Further, greater agreement was found for individuals requesting assistance in dying for their own terminal illness.

Chi-square analysis. In order to determine whether the perceptions of psychologists were distributed in a similar manner to the rule of thirds (Emanuel, 2002), a cross tabulation was conducted using the chi-square coefficient (see Chapter 3 for more information on this statistical analysis). More specifically, the distribution of psychologist perceptions surrounding the right to refuse treatment and the right to receive assistance in dying were compared to the distribution observed by Emanuel (2002): that one third of individuals supported the practice fully, one third of individuals supported the practice only in specific instances, and one third of individuals who were against the practice. Table 10 presents the results of this analysis. According to the cross tabulation, the perceptions of psychologists in this research study do not reflect the rule of thirds.

Across the personal perceptions of psychologists, a chi-square test of significance found that there was no difference between the right to refuse treatment, $\chi^2(2, N = 86) = 81.58$, $p < 0.001$ or the right to receive assistance in dying, $\chi^2(2, N = 85) = 31.15$, $p < 0.001$. Professionally, similar results were found with the right to refuse treatment, $\chi^2(2, N = 86) = 75.44$, $p < 0.001$ and the right to receive assistance in dying, $\chi^2(2, N = 86) = 27.71$, $p < 0.001$. The perceptions of the psychologists studied are not consistent with the rule of thirds in the personal and professional domains.

Table 10

Chi-Square Analysis Comparing Psychologist Perceptions and the Rule of Thirds

Item	Frequency			χ^2	df	p
	Yes	Yes, but	No			
Right to Refuse Treatment (Professional)	66	16	4	75.44	2	< 0.001*
Right to Refuse Treatment (Personal)	68	12	6	81.58	2	< 0.001*
Right to Receive Assistance in Dying (Professional)	44	34	6	27.71	2	< 0.001*
Right to Receive Assistance in Dying (Personal)	49	29	7	31.15	2	< 0.001*

Note. Yes = Yes, I believe every competent adult should have this right; Yes but = Yes, but I believe it should be allowed only in certain cases and situations; No = No, I do not believe anyone should have this right; *denotes statistically significant results ($p < 0.01$).

Research Question 2. The second research question examined 10 demographic variables in relation to psychologist perceptions on assisted death. Descriptive statistics and several univariate tests were used to address the research question. Several variables (i.e., age, years of practice, percentage of terminally ill clients on current caseload, and percentage of suicidal clients on current caseload) are presented in categorical form in order to improve the readability of frequency distributions. These same variables

remained continuous for the purposes of univariate statistical analyses. Further detail surrounding these statistical analyses can be found in the Analysis section of Chapter 3.

Descriptive statistics. Frequency distributions of the demographic variables in relation to professional and personal perceptions of assisted death can be found in Tables F1 to F6 found in Appendix F. In Table F1, participant responses to questions surrounding the right to refuse treatment and the right to receive assistance in dying were collapsed into two categories: support and against. Support includes both those who showed support and those who conditionally supported the practice. Against includes participants who indicated that they were against the practice of assisted death.

The range of scores in Table F1 was the greatest for studied females supporting the right to refuse treatment, with 58 individuals (69.5%) separating those who disagreed with the practice from those that agreed. The lowest range of scores was present for both individuals who were not sure if they have professionally supported a person with terminal illness and participants who indicated a practice length of between 30 and 34 years. In these instances the difference was 1.2% ($n = 1$) between agreeing with voluntary passive euthanasia and disagreeing with the practice. Personal and professional perceptions surrounding the right to refuse treatment and the right to receive assistance in dying were similar across all of the demographic variables. Between zero and 3.7% (i.e., approximately 2 individuals) separated these domains of perception.

Certain demographic variables showed notable distributions through Table F1 (see Appendix F). Participants with less than 5% of terminally ill clients on their caseload, as compared to those who had more terminally clients, disagreed with active and passive euthanasia as well as physician-assisted suicide. With regard to active

euthanasia and physician-assisted suicide, 7.1% of participants professionally ($n = 6$) and 8.2% ($n = 7$) personally disagreed. This is similar to the 4.7% of individuals ($n = 4$) who professionally and 7.0% personally ($n = 6$) disagreed with passive euthanasia. In addition, individuals who were not religious or spiritual and those who were uncertain about their beliefs had no disagreement, both professionally and personally, with the right to refuse treatment and the right to receive assistance in dying.

In Tables F2 to F6 (see Appendix F), frequency distributions for the vignettes are presented according to the demographic variables. For these distributions, the 5-point Likert scale was collapsed into three categories: agree (i.e., strongly agree and agree), neither (i.e., neither agree nor disagree), and disagree (i.e., strongly disagree and disagree). Across all 10 of the demographic variables, a range of zero to 27 individuals (i.e., 0.0–31.3%) separated the perceptions of euthanasia for terminal and mental illness. It should be noted that the differences demonstrated by the demographic variables are not consistent or large enough for definitive conclusions to be made regarding psychologist perceptions. Instead, more definitive statements regarding the association between demographic variables and psychologist perceptions can be found in the following section on univariate analyses.

Despite the limitation inherent in using descriptive statistics, several findings are evident from the cross tabulations presented in Tables F2 to F6 (see Appendix F). First, participants provided consistent responses across all of the demographic variables in three of the 10 vignette questions. In 10 out of the 10 demographic categories measured, between one and 48 more psychologists agreed than disagreed that they would be able to stay neutral in discussing physician-assisted death with a terminally or mentally ill

individual. In addition, between one and 64 more participants disagreed with the use of assisted death, in nine out of the 10 categories, if there is still a possibility for meaningful improvement. This was regardless of whether the client was mentally or terminally ill. Second, participants supported assisted death for terminal illness regardless of demographic variability. In all 10 categories, between zero and 22 participants separated the individuals who supported the practice from those who did not. The same can be said for the level of disagreement in relation to physician-assisted death for mental illness. Between one and 37 more participants disagreed than agreed with the practice.

Univariate statistical analysis. The original intent of this research was to conduct a nonparametric logistic regression of the demographic variables in relation to participants' perceptions of assisted death. However, the large skew of the data (i.e., skewness ranging from 0.71 to 1.99 with a standard error of 0.26) and the small size of the sample ($n = 92$) combined to produce conditions that violated the assumptions of this nonparametric test. Therefore, two univariate statistics were chosen in order to demonstrate the association between study variables. While not ideal, this was the only possibility given the current data set. The univariate statistics used are discussed in relation to each of the demographic variables. All reported statistics met the assumptions of their respective nonparametric tests.

Age. Spearman's correlation is a nonparametric analysis that measures the level of association between ordinal variables or interval/ratio variables that do not follow a normal distribution (Hanna & Dempster, 2012). While age followed a normal distribution, the perceptions of psychologists in this research did not. Therefore, Spearman's correlation was used to analyze the relationship between age and perceptions

of assisted death. Younger age was found to be negatively correlated with participant disagreement when the client was mentally ill with a chance of meaningful improvement ($r_s[83] = -0.23, p = 0.037$). No other perceptions were found to correlate with participant age.

Gender. Kendall's correlation is a form of nonparametric analysis that measures the association between ordinal variables that produce tied ranks (Hanna & Dempster, 2012). Many of the demographic variables studied in thesis, as well as the questions relating to psychologists' perceptions, produce this form of data. Therefore, Kendall's tau-b rank correlation coefficient was used to examine the association between these variables. Gender did not produce any coefficients that reached statistical significance (i.e., $p < 0.05$).

Province of practice. Kendall's correlation was used to examine the association between the studied psychologists' perceptions and province of practice. Each province was analyzed separately in order to determine which, if any, correlated to the survey questions. None of the provinces showed a significant correlation except Prince Edward Island. Residency in this province was positively associated with disagreement surrounding one's personal choice for physician-assisted death in the case of mental illness ($\tau[82] = 0.24, p = 0.018$). This correlation was significant at a 95% confidence interval.

Professional specialty. Kendall's correlation was used to identify correlations between the studied psychologists' perceptions and professional specialty. The specialties that relate to the second vignette (i.e., child and adolescent psychology, school

psychology, and professor or teaching positions) are presented in Table 11. These specialties correlate to disagreement on questions pertaining to assisted death.

Several psychologist specialties correlated with agreement on questions relating to the client's right to receive assistance in dying and the first vignette. The studied psychologist's practicing of group psychology was related to reduced disagreement, both professionally ($\tau[84] = -0.03, p = 0.019$) and personally ($\tau[85] = -0.22, p = 0.035$), surrounding the client's right to receive assistance in dying. The participant's ability to remain neutral ($\tau[84] = -0.23, p = 0.025$) and support a terminally ill client's request for euthanasia ($\tau[84] = -0.21, p = 0.046$) was correlated with the participant's practice of organizational psychology. The remaining specialties did not significantly correlate with studied psychologist's perceptions at the $p < 0.05$ level.

Table 11

Kendall's Tau-b Rank Correlation Coefficient for Participants' Professional Specialty and Vignette 2

Specialty	Value	Ability to Remain Neutral	Request Assisted Death if Client
Child and Adolescent	τ	0.21*	
	p	0.038	
	n	83	
School Psychology	τ	0.26*	0.256*
	p	0.011	0.012
	n	83	83
Professor or Teaching	τ		0.203*
	p		0.047
	n		83

Note. *denotes statistically significant correlation ($p < 0.05$).

Location of practice. Kendall's correlation was used to examine the association between the location of a psychologist's practice and his or her perceptions on physician-assisted death. The only correlation that reached a $p < 0.05$ level of statistical significance was the other category, which contained responses from clinical neuropsychology, community clinic, government, long-term care, specialized clinic, and private unpaid advocacy work (see Appendix G). This grouping of workplaces was correlated with participant disagreement surrounding a request for assisted death when a client was 30 years old and experiencing a mental illness ($\tau[83] = 0.23, p = 0.027$).

Years in practice. Spearman's correlation was used to determine the association between studied psychologists' perceptions and the length of time they have been registered as a psychologist. The only correlation to reach significance was with supporting a client's request for assisted death in the first vignette. The longer a psychologist in the current research has been registered, the more agreement they demonstrated for assistance in dying ($r_s[83] = -0.29, p = 0.009$). No other correlation attained the requisite significance with this correlation reaching a 99% confidence interval (see Appendix H).

Religious and spiritual beliefs. Kendall's correlation was used to explore the association between participants' religious or spiritual beliefs and their perceptions of assisted death. Table 12 presents the results for participants' beliefs surrounding whether or not they are religious or spiritual people. As demonstrated by the table, this demographic variable correlates the strongest with studied psychologist perceptions; many of its associations reached significance at the $p < 0.01$ level. The remaining aspects of religious or spiritual belief (i.e., moral and ethical guide, engaging in activities, aid in

end-of-life decision making) did not produce any correlations. Having religion or spirituality as a moral and ethical guide was associated with participant disagreement in response to receiving assisted death for one's own mental illness ($\tau[51] = -0.24$, $p = 0.044$). Engaging in religious/spiritual activities was also associated with disagreement. A correlation was found between increased activity and disagreement surrounding assisted death for cases of mental illness ($\tau[52] = -0.24$, $p = 0.044$). No correlations were found for the use of religion or spirituality in end-of-life decision making.

Supporting terminally ill individuals. Kendall's correlation did not find any significant associations between studied psychologist perceptions and experience personally or professionally supporting a terminally ill individual. The only association found using a Spearman correlation was lower levels of terminally ill clients correlated to participants' increased feelings of personal disagreement toward the right to refuse treatment ($r_s[86] = -0.24$, $p = 0.024$).

Suicidal clients. Spearman's correlation was also used to examine the correlation between the number of suicidal clients on a studied psychologist's caseload and his or her perceptions surrounding assisted death. Only one significant association was found between these two variables: lower numbers of suicidal clients were related to higher disagreement surrounding the ability to stay neutral in cases of assisted death with mental illness ($r_s[83] = -0.22$, $p = 0.045$).

Table 12

Kendall's Tau-b Rank Correlation Coefficients of Participants' Religious or Spiritual Beliefs and Perceptions of Assisted Death

Participant Perception	Value	Religious or Spiritual Person
Right to Receive Assistance in Dying (Professional)	τ	-0.24
	p	0.023*
	n	83
Right to Receive Assistance in Dying (Personal)	τ	-0.22
	p	0.037*
	n	84
Support Client's Request for Assisted Death (Terminal Illness)	τ	-0.26
	p	0.011*
	n	83
Able to Remain Neutral (Terminal Illness)	τ	-0.31
	p	0.003**
	n	83
Would Make the Same Request if was Client (Terminal Illness)	τ	-0.24
	p	0.2*
	n	83

Participant Perception	Value	Religious or Spiritual Person
Would Support if Client was Younger (Terminal Illness)	τ	-0.34
	p	0.001**
	n	83
Support Client's Request for Assisted Death (Mental Illness)	τ	-0.23
	p	0.029*
	n	82
Able to Remain Neutral (Mental Illness)	τ	-0.30
	p	0.004**
	n	82
Would Make the Same Request if was Client (Mental Illness)	τ	-0.23
	p	0.027*
	n	82

Note. Negative correlations represent movement toward disagreement (i.e., the more religious or spiritual an individual is, the less likely he or she will be to agree with euthanasia); *denotes statistical significance ($p < 0.05$); **denotes statistical significance ($p < 0.01$).

Professional confidence. Kendall's correlation found two associations between professional confidence and psychologists' perceptions of assisted death. Feeling trained to assess the competency of terminally ill individuals was negatively correlated with studied psychologists' level of agreement surrounding euthanasia for mental illness. Individuals who agreed that they have appropriate training indicated greater disagreement surrounding physician-assisted death for individuals with mental illness and a chance of meaningful improvement ($\tau[83] = -0.20, p = 0.042$). With regard to surveyed psychologists' professional confidence in assessing terminally ill individuals, increased confidence is correlated to increased support for euthanasia in terminally ill individuals ($\tau[84] = 0.18, p = 0.048$).

Research Question 3. The third research question examined the knowledge of registered psychologists on assisted death. In order to address this research question, descriptive statistics and a chi-square analysis were used. Further information on these analyses can be found in the Analysis section of Chapter 3.

Table 13

Frequency Distribution of Psychologist's Knowledge

Item	Physician-Assisted Suicide		Voluntary Passive Euthanasia		Voluntary Active Euthanasia	
	<i>f</i>	%	<i>F</i>	%	<i>f</i>	%
Yes, this is typically an example of euthanasia	70	83.3	36	42.9	44	52.3
No, this is not typically an example of euthanasia	10	11.9	41	48.8	28	33.3
Not sure	4	4.8	7	8.3	12	14.3
Total	84	100	84	100	84	99.9

Note. The total percentage does not add to 100% due to rounding.

Descriptive statistics. Confusion appears to exist for the surveyed psychologists surrounding the practices that constitute euthanasia. While 83.3% of participants ($n = 70$) believed that physician-assisted suicide was an example of euthanasia, only 52.3% ($n = 44$) considered voluntary active euthanasia to be a form of euthanasia. With regard to voluntary passive euthanasia, most of the studied psychologists ($n = 41$; 48.8%) did not believe that this was typically an example of euthanasia. Table 13 represents a frequency distribution of the surveyed psychologists' knowledge on euthanasia.

Chi-square analysis. A cross tabulation with the chi-square statistic was used to compare the results of this research with that of Marcoux et al. (2007). No difference was found between the results of this thesis and Marcoux et al. (2007) in knowledge of physician-assisted suicide, $\chi^2(1, N = 84) = 10.91, p < 0.001$, voluntary passive euthanasia, $\chi^2(1, N = 84) = 8.21, p = 0.004$, and voluntary active euthanasia, $\chi^2(1, N = 84) = 38.75, p < 0.001$. Table 14 provides a summary of the results.

Table 14

Chi Square Test of Psychologist Knowledge

Item	Frequency		χ^2	df	p
	Correct (Y)	Incorrect (N)			
Physician-Assisted Suicide	10	74	10.91	1	0.001*
Voluntary Passive Euthanasia	41	43	8.21	1	0.004*
Voluntary Active Euthanasia	44	40	38.75	1	< 0.001*

Note. Correct and Incorrect statements are based on the assumptions of Marcoux et al. (2007). Responses marked as not sure were collapsed, as per the comparison research, into the incorrect response category; *denotes statistically significant results ($p < 0.01$).

Research Question 4. The fourth research question examined the level of competency that psychologists possess surrounding clients who request euthanasia. In order to address this question, descriptive statistics were used. Table 15 represents a frequency distribution of the competency of psychologists.

Despite a hypothesized ability to assess competency, most of the studied psychologists appear to lack confidence ($n = 39$; 46.4%) and do not believe they had enough training ($n = 37$; 44.0%) in assessing competency at end-of-life. The majority of psychologists ($n = 73$; 86.3%) indicated they wanted more training on end-of-life assessment and decision-making issues, and education on working with the medical system.

Table 15

Frequency Distribution of Psychologist's End-of-Life Competency

Participant's Position	Possess Training		Confident in Ability		Need Training	
	<i>f</i>	%	<i>F</i>	%	<i>f</i>	%
Strongly Agree	9	10.7	7	8.3	39	46.4
Agree	20	23.8	22	26.1	34	40.4
Neither Agree nor Disagree	18	21.4	16	19.0	9	10.7
Disagree	28	33.3	28	33.3	1	1.2
Strongly Disagree	9	10.7	11	13.1	1	1.2
Total	84	99.9	84	99.8	84	99.9

Note. The total percentage does not add to 100% due to rounding. Possess Training = I possess the training necessary, as a registered psychologist, to assess the competence of terminally ill adults who are pursuing life-shortening medical treatment (i.e., physician-assisted death); Confident in Ability = I am confident in my ability, as a registered psychologist, to assess the competency of terminally ill adults who are pursuing life-shortening medical treatment (i.e., physician-assisted death); Need Training = I think psychologists should receive training in the area of end-of-life issues, such as assessment, decision making, and working with the medical system.

Summary

A series of statistical analyses were conducted in order to address the four research questions. Descriptive statistics demonstrated that the psychologists studied, primarily from Atlantic Canada, supported the practice of assisted death for individuals who are terminally ill. They did not support the practice if the individual was mentally ill or had a chance of meaningful improvement. In addition, descriptive statistics suggested that psychologists have limited knowledge surrounding assisted death. They would want training in this area because they have limited competency and confidence surrounding end-of-life concerns. Kendall's and Spearman's correlations demonstrated that the perceptions of psychologists were associated with nine out of the 10 demographic factors studied. In addition, two chi-square analyses indicated that (a) psychologist perceptions do not align with the rule of thirds and (b) psychologist knowledge of euthanasia and assisted death does not align with that of the general public described by Marcoux et al. (2007). These results, as well as the limitations of the study and the future directions for research, policy, and practice, are explored in the next chapter.

Chapter 6: Discussion

As has been made evident by the results of the previous chapter, assisted death is a complicated and controversial issue. In this chapter, the aforementioned results are explored in further detail and discussed in the context of the current literature. In addition, the strengths and the limitations of this research are also discussed in order to provide a foundation for future research, policy, and practice.

Discussion of the Results

Demographic properties. In total, 92 registered psychologists, with an average age of 50 years old, were recruited to participate in this research. Nearly 60% lived in Atlantic Canada with the remainder being from British Columbia, Saskatchewan, and Manitoba. Over half of the participants were female, clinical psychologists, and had practiced for less than 15 years. In addition, approximately 50% worked in either private practice or hospital settings. Over half of the participants studied indicated that they were religious or spiritual individuals. Of this group, approximately 40% claimed that their beliefs assisted in moral decision making and nearly 65% identified their beliefs as useful in decision making surrounding end-of-life. Less than 50% of the surveyed psychologists had professional experience supporting individuals with terminal illness. This is in contrast to over 50% of participants who expressed personal experience in providing support to terminally ill individuals. In addition, approximately 6% of participants' current caseloads consisted of individuals with terminal illness. In contrast, 15% of their caseloads were reported as consisting of suicidal clients.

What preliminary knowledge do Canadian registered psychologists possess surrounding the practice of assisted death? Descriptive statistics and a chi-square analysis revealed that approximately 80% of surveyed psychologists considered physician-assisted suicide to be an example of euthanasia. This is consistent with the confusion that exists in the literature over whether physician-assisted suicide constitutes a form of euthanasia (Varelius, 2013). In addition, just under 50% of studied psychologists considered passive euthanasia to be an example of euthanasia. The aforementioned result reflects the views of Sumner (2011), who believes that no distinction should be made between these two different practices. Just over 50% of participants believed that actions consistent with active euthanasia were a form of euthanasia. This is constant with Marcoux et al.'s (2007) finding that many Québec citizens studied could not accurately distinguish between end-of-life practices.

The chi-square analysis further revealed that the confusion expressed by participants in Marcoux et al.'s (2007) study was statistically different than the confusion expressed by psychologists in the current study. In other words, psychologists within this inquiry appeared to express greater confusion surrounding the practices that constitute euthanasia (i.e., active and passive euthanasia). As referenced in both Chapter 3 and in the previous paragraph, a difference in opinion exists in the literature surrounding which practices constitute euthanasia and what distinctions need to be made in defining its umbrella term, assisted death. To some, physician-assisted suicide and the withdrawal or refusal of treatment are forms of euthanasia. To others, these practices cannot be captured under the term euthanasia: they reflect assisted death. This provides substantial variation in the research on individual perceptions surrounding these practices. In

addition, this makes it difficult for individuals who are uneducated about the debate surrounding the term euthanasia to understand what practices are, and may be, legalized.

An additional explanation for the increased confusion by studied psychologists is the fluidity of the term euthanasia. As discussed in Chapter 1, euthanasia has been referred to by many names, each of which captures a different normative and semantic aspect of the act of assisting a terminally ill individual in dying. The confusion identified by this thesis, and the study by Marcoux et al. (2007), may not be confusion surrounding what constitutes euthanasia. Instead, the confusion may be a reflection of the term euthanasia, as a form of assisted death, and its existence in a state of flux. Future research should examine the semantic and normative influences people place upon the term euthanasia. This would clarify whether the confusion found in this study, and the research by Marcoux et al. (2007), is a true lack of knowledge.

An alternative explanation to the results of study relates to the use of the term euthanasia. Individuals who are well versed in the literature on assisted death may have been confused as to what the researcher might have meant by euthanasia. As stated in Chapter 3, the distinction between active and passive euthanasia as forms of assisted death has been highly debated. This may have led some participants to respond with their perceptions regarding the distinction between practices rather than their actual knowledge. Future research should clearly outline the terminology used in order to ensure that knowledge is measured and that assisted death is accurately depicted.

In summary, the results of this thesis and the work of Marcoux et al. (2007) suggest that there is a need for education surrounding euthanasia and other forms of assisted death. Increased understanding would allow individuals to be more informed

about the debate and to be better able to participate in meaningful discussions surrounding this issue.

To what extent do Canadian registered psychologists feel confident in their abilities and training for assessing the competency of individuals requesting assistance in dying? Descriptive statistics revealed that just under 50% of surveyed psychologists expressed they lacked confidence in their ability to assess the competency of terminally ill individuals. Further, approximately 45% of responding psychologists did not believe that they have sufficient training to perform this skill. These findings contrast the statements made by Niederjohn and Rogers (2009), who suggested that psychologists possess the ability to assess terminally ill individuals at end-of-life. It is puzzling why the psychologists in this thesis expressed a lack of confidence surrounding psychological assessment because many psychologists perform assessments in the form of initial intake interviews and the determination of mature minor status. However, it is possible that the psychologists surveyed equated confidence to the receipt of training in assessing individuals who are terminally ill. An additional possibility is that the psychologists studied did not consider themselves to be competent at providing assessments. Further, these individuals may not have felt confident working with clients who are terminally ill. Future research may need to separate these factors in order to make a determination regarding psychologist competency.

Over 85% of psychologists studied expressed an interest in professional development relating to end-of-life issues such as assessment, decision making, and working with the medical system. Unfortunately, no training programs currently exist (Werth et al., 2009) that would meet the demands of this professional population. With

increases expected in the number of individuals who are terminally ill (World Health Organization, 2005) and over the age of 65 (Statistics Canada, 2010), psychologists may be expected to more readily assess and work with end-of-life concerns. The question remains, how will psychologists be able to perform this task if they cannot practice due to insufficient training?

In summary, the results of this research demonstrate that the psychologists studied are aware of their limitations in working with end-of-life concerns. They lack both the confidence and training to assess the competency of individuals who are terminally ill. Training is required and desired by surveyed psychologists in order address this concern. Through professional development, psychologists can be prepared to meet the needs of a changing client population.

What are the personal and professional perceptions of Canadian psychologists on assisted death? Over 50% of psychologists surveyed demonstrated support for an individual receiving medical assistance in dying. This was consistent across both professional and personal perceptions, with both receiving support from over 90% of the participants. In addition, approximately 80% of the psychologists studied indicated that they would be willing to remain neutral (i.e., not influence the client) if a terminally ill client requested assistance in dying. These responses are consistent with the current literature on the perceptions of the general public and individuals with terminal illness on active euthanasia and physician-assisted suicide. For example, an Angus Reid Global (2010) public opinion poll involving 1,005 respondents found that 67% of Canadian citizens studied supported the practice of active euthanasia. Likewise,

nearly 63% of surveyed terminally ill individuals supported legalizing assistance in dying (Wilson et al., 2007).

The responses in this study did not follow the rule of thirds (Emanuel, 2002). It was expected that approximately 33% of responding psychologists would fully support the practice of assisted death with 33% conditionally supporting the practice and 33% being completely against. Instead, this study found that participants were more fully supportive of the practice than the rule of thirds describes, with nearly 60% of sample psychologists fully supporting the right to receive assistance in dying. In contrast, about 30% conditionally supported the practice, and less than 10% were completely against when asked about their personal perceptions.

It is a possibility that the higher rates of support than expected could be the result of surveyed psychologists making the decision based on what they believe is a client right—to decide whether to receive or terminate treatment. This would be consistent with first principle (i.e., respect for the dignity of persons) outlined in the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000). Alternatively, the rates of support may be falsely elevated by only having participants from five of the 13 Canadian provinces and territories. This provides a disproportionate sample of Canadian psychologists' perceptions surrounding euthanasia that is not generalizable to the entire population. An additional alternative to explain these results relates to the recent events in Québec and within the Supreme Court of Canada. Changes in Canadian society surrounding physician-assisted death may have polarized how the surveyed psychologists respond to the practice. Further, a lack of clarity in the terminology may have allowed participants to interpret the question differently; for example, “meaningful

improvement” may mean different things to different individuals. The survey instrument used was constructed to measure perceptions surrounding active euthanasia. However, ambiguity in the terminology may have resulted in a survey that measures several practices under physician-assisted death. This provides a strong limitation to the validity of the results. A final possibility to explain these results is the studied psychologists’ lack of knowledge surrounding active euthanasia and other related practices. For example, if a psychologist was not aware that physician-assisted suicide was different than voluntary active euthanasia, then this person might have a tendency to more or less fully support the practice. Perhaps if the researcher had asked the reasons for the responding psychologists’ perceptions more insight would be available to interpret why support was so high for the practices of voluntary active euthanasia, physician-assisted suicide, and passive euthanasia.

The psychologists in this study were also asked if they believe clients had a right to end their lives if the suffering was due to a mental disease (e.g., depression). Overall, the surveyed psychologists in this study demonstrated, both from their personal and professional opinions, they were not certain if the client should have this right given that mental disease was the reason given for wanting to die. In particular, just over 70% of participants indicated that they would be unwilling to support a client if such a request were made. Further, just over 50% of surveyed psychologists indicated that they would be able to remain neutral in discussing a request for physician-assisted death with a client suffering from mental illness. This result is not surprising because assistance in dying for individuals with a mental disease is not a frequently recognized form of the practice. However, if the responding psychologists knew that active euthanasia for mental illness

is viable in Belgium and the Netherlands (Schüklenk et al., 2011), it would be interesting to note whether their opinions would change. This is an area that has not been previously studied in the literature.

In summary, the results of the current study demonstrate that the surveyed psychologists were more supportive of the most common conceptualization of assisted death (i.e., terminal illness) than for the less discussed practice (i.e., mental illness). In addition, personal and professional opinions were demonstrated as being similar across the study. It appears that the psychologists studied practice, in this particular instance, in a manner consistent to their personal views. Alternatively, the responding psychologists may have internalized the ethical practice detailed in the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000), which may have resulted in the similarity of opinions. Regardless, the psychologists in this study did not express much differentiation in their perceptions.

How do demographic factors predict the perceptions of Canadian psychologists on assisted death? Descriptive statistics and two univariate analyses highlighted the relationship between the 10 demographic variables and psychologist perceptions on assisted death. All 10 variables are interpreted in this section and only the results of the univariate analyses are discussed

Age. Younger age was found to negatively correlate to the studied psychologist perceptions surrounding assisted death for mental illness. That is, the lower the age of the participant, the more likely he or she was to disagree with assistance in dying for a client who was mentally ill and had a chance of meaningful improvement. While age has not been found to be a factor in assisted death perceptions surrounding mental illness, it

has been correlated to perceptions surrounding assisted death for terminal illness. Catt et al. (2005) found older age (i.e., persons aged 60 years old and over) was related to an positive perceptions of active euthanasia for terminal illness at end-of-life. It would be interesting to note why younger responding psychologists appear less supportive of assisted death than their older counterparts. This information would emerge from having participants justify the reasoning behind their perceptions. In addition, it would interesting to note whether the measurement of age as a categorical or continuous variable had an impact on the results. Age, as a variable that is not always linear, appears to be inconsistently measured across the literature such that comparisons of the research may not accurate.

Gender. Unlike age, gender did not produce any significant correlations to psychologist perceptions surrounding assisted death. This is in contrast to the study by Levy et al. (2013), who found that males demonstrated more agreement than females surrounding the practice of active euthanasia and physician-assisted suicide. It is possible that the high number of females (78%) surveyed in this research reduced the likelihood of finding a gender effect. Future research should weigh demographic variables, such as gender, in order to ensure that the results found are representative of the population. This was not possible for the current thesis as a result of a lack of research on female, Canadian, registered psychologists, who self-selected to participate in a study of assisted death. An alternative reasons for the lack of an association for gender is that the research by Levy et al. (2013) was based in Israel with physicians and the current study relied on psychologists residing in Canada. The difference in study

populations may have resulted in the disparity with regard to participant gender and its association to healthcare practitioners' perceptions of assisted death.

Province of residence. In this discussion, only the provinces of British Columbia and Prince Edward Island are explored. The remaining provinces studied (i.e., Manitoba, New Brunswick, and Newfoundland and Labrador) did not produce significant correlations or did not differ strongly from the results of the literature. Residency in Prince Edward Island was found to positively correlate with disagreement surrounding one's personal choice to receive assistance in dying. That is, individuals from this province were less likely to agree with assisted death for themselves if they were mentally ill. This is consistent with a recent Angus Reid Global (2010) poll that found residents of Atlantic Canada to be less supportive of active euthanasia than individuals from the other Canadian provinces. No correlation was found with the other provinces from Atlantic Canada in this study (i.e., New Brunswick and Newfoundland and Labrador). In addition, the current study found no correlation for residency in British Columbia. In other words, living in British Columbia appeared not to be related to perceptions surrounding assisted death. This is in contrast to the Angus Reid Global (2010) poll, which identified residents from British Columbia as being most supportive of active euthanasia. Several alternatives exist that may explain this finding. First, it is a possibility that a small sample size ($n = 92$) may have compromised this study's ability to evaluate provincial perceptions. Second, the time between this study and the Angus Reid Global (2010) poll of Canadian perceptions may have led to changes in provincial opinions. Third, the perceptions of the responding psychologists may differ from the perceptions of the general public in each province.

Professional specialty. School and child or adolescent psychology were professional specialties found to positively correlate with the ability to remain neutral. In other words, participants who practiced school and child or adolescent psychology are more likely to disagree (or possibly influence) a client's choice, in the event the client was mentally ill and requesting assistance in dying. Further, respondents who practiced school psychology or were professors were less likely to request assistance in dying themselves if they had a mental illness. Conversely, the group psychology professional specialty was negatively correlated to personal and professional perceptions surrounding the right to receive assistance in dying. That is, surveyed psychologists who indicated their professional specialty as group psychology were less likely to professionally and personally disagree with voluntary active euthanasia and physician-assisted suicide. Finally, the ability to remain neutral and support a terminally ill client's request for euthanasia was negatively correlated with the specialty of organizational psychology. In other words, participants who practice organizational psychology were less likely to support a client with terminal illness in their request for assisted death. In addition, these psychologists were less likely to remain neutral in working with terminally ill individuals requesting assistance in dying.

The finding that professional specialty relates to individual perceptions is consistent with Emanuel's (2002) review of the literature and Levy et al.'s (2013) study of physicians in Israel. It is a possibility that the difference in specialty may be a result of different training, experiences, and theoretical approaches. Alternatively, it may be a result of different personalities being drawn to different branches of psychology. Further research would need to be conducted in order to support any of these explanations. For

the current study, these differences may present a limitation to the analysis of the current, aggregated data. Future research should examine specific psychological disciplines in relation to perceptions surrounding assisted death.

Location of practice. A positive correlation was found between the category of other forms of practice and surveyed psychologist perceptions of assisted death. In other words, individuals in less common locations of practice (i.e., clinical neuropsychology, community clinics, government, long-term care, specialized clinics, and private advocacy work) were more likely to disagree with assistance in dying when a client was 30 years old and experiencing a mental illness. No research has previously been conducted on the relationship between practice location and psychologist perceptions.

Years of practice. Surveyed psychologists' perceptions of assisted death for terminal illness were found to negatively correlate with the number of years a psychologist has practiced. That is, the fewer years a participant has practiced as a psychologist, the more likely they were to disagree with assistance in dying. It is possible that a mediating factor, such as experience with client suffering or with ethically difficult areas, may be involved. No research has previously been conducted on the years of professional practice and perceptions of assisted death.

Religious or spiritual beliefs. Self-identifying as a religious or spiritual person was found to be the strongest correlating factor out of the 10 demographic variables assessed to influence the responding psychologists' perceptions on assisted death for mental illness and terminal illness. That is, the greater a participant's religious or spiritual beliefs, the more likely he or she is to disagree with physician-assisted death. This finding is consistent with the results reported by Emanuel (2002), Givens and

Mitchell (2009), Moulton et al. (2006), Parpa et al. (2010), and D. M. Wilson et al. (2013). In addition, no significant correlations were found in those who responded for religion as an aid in making end-of-life decisions. In other words, the amount a respondent relies on his or her religion or spirituality for end-of-life decision making is unrelated his or her perceptions surrounding assisted death. This is in contrast to the work of Givens and Mitchell (2009), who found that individuals who had faith in the helpfulness of their religion were less supportive of active euthanasia as a practice.

Experiences with terminally ill clients. Higher numbers of terminally ill clients on the surveyed psychologists' caseloads were negatively correlated with positive perceptions of passive euthanasia. That is, participants were more likely to agree with the right to refuse treatment if they had higher numbers terminally ill clients on their caseload. This is consistent with the work of D. M. Wilson et al. (2013), who found that individuals who have euthanatized a pet, supported someone who was terminally ill, or developed an advance directive were more likely to support practices involving assistance in dying. It would be interesting to note whether the psychologists who responded would be more supportive of the right to refuse treatment if they were given the opportunity to work with terminally ill clients or received training surrounding end-of-life concerns.

Experiences with suicidal clients. The perceptions of the psychologists surveyed demonstrated a negative correlation with the number of suicidal clients on their caseloads. In other words, the greater the number of suicidal clients on the studied psychologists' caseloads, the more support they appear to offer towards remaining neutral when working with a mentally ill client requesting assistance in dying. No prior research

has been conducted on the relationship between experience with suicide and assisted death. Therefore, no research can be compared to this finding. However, it is possible that these findings are a result of surveyed psychologist inexperience in staying neutral with clients who are considering ending their own lives.

Professional confidence. Beliefs surrounding level of training were negatively correlated with participant perceptions of assisted death for individuals with mental illness. That is, studied psychologists were less likely to agree with physician-assisted death when there was a chance of meaningful improvement if they did not believe they had the appropriate training to assess the competency of terminally ill individuals. Further, feelings of professional confidence were positively correlated with increased participant support for assisted death. In other words, respondents with lower levels of professional confidence in assessing the competency of terminally ill individuals were less likely to support assistance in dying for terminal illness. Possible explanations for these results include the first-time nature of the request in each vignette and a belief that mental illness impairs competency. No prior research has been conducted on the relationship between training, confidence, and perceptions of assisted death. It would be interesting to note whether psychologists, when exposed to training programs to improve confidence and competency, would offer greater support for assisted death for terminal or mental illness.

Summary. Overall, the results of the current research indicate that nine out of the 10 demographic variables studied influence the perceptions of surveyed psychologists on assisted death: age, province of practice of practice, professional specialty, location of practice, years of practice, religious or spiritual beliefs, professional and personal

experience of supporting terminal illness, number of suicidal clients, and professional confidence. Future research should examine the effect size of this influence in order to understand how psychologists' perceptions may change over time. It is possible that the demographic variables studied may have been influenced by the limitations of this research (e.g., having only five of the 13 provinces and territories accounted for). Future research should attempt to access the full Canadian population of registered psychologists in order to produce more generalizable data.

Overall conclusions. Overall, the results of this thesis indicate that the majority of studied psychologists support the client's right to withdraw or discontinue treatment as well as the right to receive assistance in dying for terminally ill individuals. For individuals with mental illness, the majority of psychologists surveyed appear to disagree with the practice of assistance in dying. While the psychologists in this study agree with assisted death for terminally ill adults, there appears to be misunderstanding surrounding the actions or inactions that constitute euthanasia. This is an area in which professional education appears necessary, as psychologists may need to know the terminology, once agreement is reached within the literature, in working with individuals who may make such requests. Professional education also seems necessary for psychologists to increase their confidence in providing assessments of competency for terminally ill adults.

Psychologists who completed this survey indicated that they would be able to stay neutral in assisting clients to weigh the benefits and detriments of their decisions; however, many express an interest in training as a method of improving their abilities. The conclusion of this thesis stipulates that psychologists do have a place in the current euthanasia debate—

policy-makers, researchers, and psychologists themselves may need to recognize the potential that these professionals have to offer.

The first half of the current chapter provided a comprehensive discussion of the study results in the context of the current literature. Gaps in the literature were identified as well as potential directions for future research and professional development. The second half of the current chapter offers an evaluation of this research. The strengths and limitations of this study are explored before discussing future direction for research, policy, and psychological practice.

Strengths of the Research

The most obvious strength of this thesis research is that it represents the first attempt at studying the perceptions of psychologists on the practice of euthanasia. A comprehensive review of the terms “assisted death” and “psychologist” in the EBSCO, ProQuest, and Ovid databases as well as Google Scholar found only 14 articles that addressed the relationship between psychologists and assisted death. None of these articles presented original research pertaining to this subject area. Therefore, the current thesis is not only the first in its area, but also an important step to bridging the gap between psychologists and the practice of assisted death.

Another strength of this thesis is the survey used to measure psychologist perceptions. Comprised of questions modified from previous assisted death research, this survey is able to connect the perceptions of psychologists to that of the general public, terminally ill, and medical doctors. It is able place the current knowledge of these professionals at a comparable level to previously studied populations. In addition to the questions used, this survey is strong in its ability to evaluate the perceptions of

psychologists toward both terminal and mental illness. While terminal illness has been well explored in the literature, mental illness is less commonly discussed. It is an area that has not been well studied and is particularly relevant to psychologists.

A final, but equally as important, strength is the new and informed perspective this thesis provides to the debate on assisted death. As discussed in Chapter 2, psychologists have the potential to play a significant role in the future of this controversial practice. Therefore, they should be included in the debate in relation to competency, patient rights, and mental illness. This thesis is strong in that it provides a catalyst for psychologists to begin to discuss end-of-life issues. In addition, it provides an informal invitation to the discussion on active euthanasia and physician-assisted suicide.

Limitations of the Research

Despite the significant strengths that emerge from being the first study of its kind, this thesis demonstrates several limitations that can be improved upon in future research but currently limit the generalizability of the thesis findings. The first limitation was that the wording of the questions may have led participants to respond based on personal interpretations. For example, the use of “meaningful improvement” or “assistance in death” rather than “assistance in suicide” may have been sufficiently vague to allow participants to interpret these statements in a manner inconsistent with the intention of the researcher. Specifically, the term assistance in dying could refer to many end-of-life activities such as passive euthanasia, active euthanasia, and physician-assisted suicide. Future research should ensure that questions do not leave room for interpretation by conducting a pilot test to ask individuals to indicate what interpretations they make from

the phrasing. This would allow researchers to produce stronger and less tendentious questions.

The second limitation was in regard to the initial screening question, which asked participants whether or not they were registered psychologists practicing within Canada. While assisting in identifying eligible participants, the question did not discourage malingering from individuals who were not psychologists. Future research should use a more discriminating research question in order to avoid such problems. For example, the survey question could ask potential participants under which regulatory college he or she is registered. This is information that a psychologist would easily be able to provide and a member of the general public would not know off hand. Therefore, it would serve as a more effective screening question.

A third limitation to this thesis was the low reliability of the knowledge section of the survey instrument. As mentioned in the “Discussion of the Results” section of this chapter, the low reliability could be accounted for by the number of questions, the first-time nature of the instrument, the varied outcomes being measured (i.e., passive euthanasia, active euthanasia, and physician-assisted suicide), and the terminology used in the question. Future research can improve upon the reliability by expanding the knowledge section and focusing more on a single area rather than multiple aspects of end-of-life care. In order to provide a foundation for future research, many areas had to be examined by this thesis. However, future research should focus on the specific aspects of psychologists’ knowledge surrounding euthanasia.

A fourth limitation to this research was the wording of the questions in relation to the rule of thirds. As the survey currently stands, only questions with a 3-point scale

(i.e., yes, conditionally yes, and no) can be compared to this distribution phenomenon.

The responses following the vignettes, which examine the conditions psychologists place on their perceptions, do not follow this response style and thus cannot be compared to the rule of thirds. Future research should examine these vignettes in the context of the 3-point Likert scale. This would provide more data on psychologists' perceptions and on how the rule of thirds changes when different conditions (e.g., typical versus atypical euthanasia) are involved.

A fifth limitation to this thesis was the use of Facebook (2015) as a recruitment tool. As discovered by the researcher, the majority of Canadian psychologists do not appear to list their profession on their personal profiles. Thus, only 20 individuals were able to be targeted through a Facebook (2015) advertisement. Potential reasons for this trend include privacy protection as well as the use of business pages to advertise their services rather than personal pages. In the future, alternative measures should be used to recruit Canadian registered psychologists, such as the use of provincial psychologist organizations rather than social media.

In response to the difficulty with social media, the researcher approached provincial associations to recruit participants. A significant limitation to this method was that several provinces (i.e., Yukon, Northwest Territories, Nunavut, and Québec) were unable to participate in the study due to either privacy concerns, the lack of a provincial association, or difficulty with participant accessibility. This limited the generalizability of the findings. The most significant of these losses was Québec, as this province recently passed Bill 52: An Act Respecting End-of-Life Care (2014). The researcher initially approached Québec's psychological association but later concluded that

including these individuals in the results would potentially skew the data. Bill 52, having been passed at the beginning of data collection, may have led Québec psychologists to respond in a political manner rather than in a way that truly reflected their beliefs. This would potentially affect the distribution of the results and, in turn, create an incorrect image of Québec and Canada as a whole. Future research should study the perceptions of psychologists, and other individuals, from Québec in order to determine individual beliefs in response to the legalization of medical assistance in dying. In addition, future research should examine the perceptions of registered psychologists living in the provinces not accessible to the current thesis.

A seventh limitation to the current thesis was the researcher's reliance on secondary sources. Secondary sources, such as Schüklenk et al. (2011), can provide insight into trends that appear in the literature; however, these insights may be biased by the author's perspective surrounding assisted death. Future research should only examine primary sources in order to determine whether the interpretations made by secondary sources are accurate. In addition, research by independent studies should be used to examine the prevalence of assisted death practices around the world. This thesis primarily used the research of government bodies (e.g., Statistics Netherlands) that may be biased by unreliable reporting: individuals may not report illegal practices or underreport the frequency of legal practices in order to make themselves look good.

A final limitation to this thesis was the amount of information presented in the vignettes. For each scenario, the frequency with which the client requests assistance in dying was not directly stated. However, it was implied that this was the first time that the individual requested support. One participant noted that this lack of information skewed

his or her results. The Oregon standard insists that a patient make a request three times before receiving support for the practice (Winograd, 2012). This participant found it difficult to respond because the vignette did not actively conform to this standard. Future research should correct this potential confound by integrating this information into the vignettes. This would allow participants sufficient information to clearly indicate their views surrounding physician-assisted suicide and active euthanasia.

Future Directions for Research

This thesis has laid the groundwork for future research on the relationship between psychologists and the practice of physician-assisted death. In this section, the following areas are discussed as extensions of this research: (a) dementia as an atypical case of assisted death, (b) perceptions of psychologists on pain management, (c) qualitative research on the conceptualization of assisted death in psychologists, and (d) perceptions surrounding assisted death for those with limited competency such as children.

Dementia as atypical assisted death. The current study demonstrated that approximately 11% of psychologists would support a client's request for receive assistance in dying if the client had mental illness. This is in contrast to the over half of psychologists surveyed who would support the request if the client were terminally ill. These results seem to suggest a distinction between what practices are considered acceptable and unacceptable for individuals receiving assistance in dying. It would be interesting to note whether dementia, which has properties of both terminal and mental illness, would be accepted as an appropriate use of active euthanasia and physician-assisted suicide.

In the literature, the permissibility of active euthanasia and physician-assisted suicide for individuals with dementia appears to be a contentious issue. Under Dutch Law, persons with dementia may request assistance in dying if it has been outlined in an advance directive (Gastmans & de Lepeleire, 2010) and they meet the due care criteria discussed in Chapter 2 (Hertogh, de Boer, Dröes, & Eefsting, 2007). In 2012, 42 individuals met these criteria and were able to receive assistance in dying (Regionale Toetsingscommissies Euthansie, 2012). Many more requests may have been received because up to 76% of advance directives for assistance in dying are ignored by physicians (Rurup, Onwuteaka-Philipsen, van der Heide, van der Wal, & van der Maas, 2005).

Research on individuals with dementia, their caregivers (Denning, Jones, & Sampson, 2013), relatives (de Boer, Dröes, Jonker, Eefsting, & Hertogh, 2011), the general public (Televantos, Talias, Charalambous, & Soteriades, 2013; Williams, Dunford, Knowles, & Warner, 2007), and physicians (de Boer et al., 2011; Rurup et al., 2005) show a lack of support for the practice. The general public is the most supportive with approximately 60% of people ($n = 725$) wanting physician-assisted suicide in the event that they develop severe dementia (Williams et al., 2007). This is consistent with the perspective that a future with a debilitating condition is not worth living. “People often think prospectively that they would find a particular disabling condition ‘unbearable’ or ‘worse than death,’ only to find when they actually experience it that it is not nearly as bad as they thought it would be” (Menzel & Steinbock, 2013, p. 487). Physicians do not share this perspective because active euthanasia and physician-assisted suicide for dementing conditions “goes against the fundamental moral responsibilities of physicians” (Hertogh et al., 2007, p. 50). In addition, it ignores the fact that the interests

of an individual, and in many cases his or her identity, change as a result of the dementia (Menzel & Steinbock, 2013).

Future research should examine the perceptions of psychologists on the use of assisted death for individuals with dementia. Since psychologists are required to have training in the cognitive and biological basis of behaviour (College of Alberta Psychologists, 2013), these professionals have a sufficient foundation to understand the many changes that can occur as a result of a dementing condition. In addition, psychologists' ability to assess competency (Niederjohn & Roger, 2009) and ensure that individuals are acting according to their current value system (Haley, Larson, Kasl-Godley, Neimeyer, & Kwilosz, 2003) can protect the client from receiving unwarranted assistance in dying. The *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000) dictates that psychologists have a responsibility to those who are most vulnerable in society. Therefore, future research should examine the perceptions of psychologists on active euthanasia or physician-assisted suicide for dementing conditions. This would serve as a first step toward accepting this responsibility.

Perceptions of psychologists on pain management. Future research should also consider the perceptions of psychologists on the practice of pain management. Currently, more than 50% of patients are reported as experiencing pain at the end of life, with one third of these individuals reporting this pain as being moderate to severe in nature (van den Beuken-van Everdingen et al., 2007). Physicians concerned about the doctrine of double effect do not sufficiently engage in pain management for their patients, which results in many individuals dying while still in pain (Fohr, 1998). According to Orr

(2001), effective pain management is taking the “ethical high ground” (p. 132) when dealing with individuals at the end of life. Further, with no research demonstrating that pain management through opiates leads to hastened death, there is “no longer any excuse for inadequate pain management” (Orr, 2001, p. 135).

Psychologists are often involved in pain management in the context of rehabilitative medicine (Taylor, 2001). However, very few articles mention the psychologist’s role in providing end-of-life care. While unable to administer medication (Robiner, Tumlin, & Tompkins, 2013), psychologists are often involved in evaluating individuals who request treatment to reduce refractory symptoms such as “pain, nausea, vomiting, delirium, bleeding, as well as psychological or existential distress” (Sadler, 2012). In this role, psychologists have an ethical responsibility to protect client autonomy and the right for an individual to make an informed decision regarding treatment (Taylor, 2001). In addition, the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000) outlines a psychologist’s responsibility to protect individuals from actions that may cause “serious physical harm or death” (p. 19). Clients who are terminally ill and suffering may need a psychologist to advocate for pain-reduction methods.

An important area of concern for psychologists may be the use of palliative sedation for treating existential and psychological pain. According to Sadler (2012), palliative sedation refers to the use of sedatives to lower a person’s consciousness in order to reduce the experience of refractory symptoms. Individuals experiencing existential distress, a concern similar to psychological distress, may receive palliative sedation as a method of reducing these symptoms (Sadler, 2012). The question for

psychologists, as a participant in a study on palliative sedation inquired, “Can the lack of a meaningful existence be treated with sleep?” (Blondeau, Roy, Dumont, Godin, & Martineau, 2005, p. 243). This is a question that, in the context of understanding pain management, should be asked in future research on end-of-life treatments and practices.

Qualitative research on psychologists and assisted death. The current study provided a quantitative foundation for understanding the perceptions of psychologists on assisted death. Future qualitative research should be conducted in order to elaborate and provide a clearer understanding of psychologists’ perceptions surrounding the practice. A comprehensive search of the EBESCO, ProQuest, and Ovid databases suggests that qualitative research has been conducted on individuals who are terminally ill, physicians, and family members of the terminally ill. In order to align with these groups, the perceptions of psychologists must be studied in a similar manner. This would allow future comparison studies in which the views of psychologists, and other individuals involved in the practice, could be examined.

In addition, studying psychologists qualitatively may provide a rich resource to understanding why the trends found in this research have occurred. For example, a qualitative study may explore the decision-making process that psychologists undergo when determining whether or not to support a request for assistance in dying. Engaging in such research may explain how 41.7% of the surveyed psychologists came to agree with the practice for themselves if they were terminally ill. Further, future research could provide a basis for understanding the general moral principles that psychologists apply toward other controversial concerns (e.g., teenage abortion).

Perceptions of euthanasia on those with limited competency. In this research, approximately 45% of psychologists did not express confidence in their ability to assess the competency of terminally ill individuals. Psychologists' beliefs surrounding euthanasia for individuals with already limited competency require further exploration. Traditionally, persons with limited competency (e.g., young children and individuals with developmental disabilities) were unable to receive assistance in dying (Schüklenk et al., 2011). However, recent legislation in Belgium (McDonald-Gibson, 2014) and the current debate on euthanasia for persons with dementia (Menzel & Steinbock, 2013) appear to challenge this position. Future research should examine the perception of psychologists on this emerging practice. Psychologists are regularly involved with assessing competency (Niederjohn & Rogers, 2009) and, therefore, may be able to provide valuable insight into the cognitive and decision-making abilities of those with limited competency. In addition, psychologists may have the ability to advocate for the individuals in their care.

Future Directions for Policy

This study is the first of its kind to examine the perceptions of psychologists surrounding assisted death. As such, it has set the foundation for future policy development and debate surrounding the legality of the practice. Psychologists, as evident by the literature discussed in Chapter 2 and the current findings, should be included in the debate. They have the potential to develop the unique skills and knowledge to be able to simultaneously inform the debate and protect the welfare of the patient, were active euthanasia or physician-assisted suicide to be legalized.

A shift away from medicalization. Including psychologists in both the current debate and policy development represents a shift away from medical paternalism. Medical paternalism, according to Sherwin (1992), occurs when physicians make decisions for patients without fully understanding the nature of consent. Medical practitioners encourage dependence and fear in patients by promoting themselves as objective experts who can make decisions that reflect the patient's best interest (Sherwin, 1992). This creates the illusion of choice and masks the normalizing influences of medical institutions (Sherwin, 1998). In the assisted death debate, medical paternalism is made evident by the majority of research appearing to focus on the perceptions of medical professionals. In addition, this form of paternalism is also made evident by the fear of terminally ill individuals toward physicians' abuse of power if active euthanasia or physician-assisted suicide were to be legalized (Karlsson et al., 2012).

In order to move away from the current paternalism that exists in the medical system, Sherwin (1992) suggested two methods of maximizing the patient's decision-making ability. First, she suggested involving patients in the process of making medical decisions (Sherwin, 1992). This is something that is limited in the current medical model. Second, physicians need to recognize that they only have technical expertise; they do not possess knowledge surrounding making good decisions, the patient's needs, the social context of the decision, and the patient's distress, values, and coping strategies (Sherwin, 1992). Psychologists are some of the few professionals who possess such knowledge and, therefore, should be included in the current debate and the potential practice of active euthanasia and physician-assisted suicide. This shifts the power away from the medical system and back toward the patient.

A shift in language. In addition to the shift away from medical paternalism, a shift in language may occur if psychologists are included in the assisted death debate. According to Sherwin (2001), metaphors, a key aspect of language, “do not only illuminate and connect various aspects of the domain to which they are applied, they also obscure and distort others aspects” (p. 345). With assisted death, this is best exemplified with the warrior metaphor. In this metaphor, according to Vamos (2012), an individual has “the ability to control the circumstances of death, to fight a battle against it, [and the family is able to claim] autonomy and agency for the dead person” (p. 84). This leads to the denial of grieving and the masking of the need for palliative care resources (Vamos, 2012).

Psychologists may have the ability to change the language of the debate on assisted death such that it is more focused on the terminally ill individual and the circumstances that lead them to make such a choice (Sherwin, 1998). This is an important change in focus that reduces the masking of medical paternalism, the illusion of choice (Sherwin, 1992), and the lack of need for palliative care (Vamos, 2012). Psychologists have a responsibility to the most vulnerable members of society as well as a responsibility to act against societal problems (Canadian Psychological Association, 2000). Changing the language of the debate on assisted suicide is one way that both of these responsibilities can be met.

Future Directions for Psychologists

Training. As over 85% of the psychologists studied expressed an interest in end-of-life training, future professional development should focus on meeting this need. Currently, no such programs exist for psychologists (Werth et al., 2009), as the role of

mental health professionals in this area continues to go unrecognized (Kasl-Godley, King, & Quill, 2014). Psychologists are able to provide services to patients and their families before the illness, after diagnosis, during late-stage illness, and after patient death (Haley et al., 2003). In order to provide these services, psychologists may require training (Canadian Psychological Association, 2000) in order to develop their “death competence” (Gamino & Ritter, 2012, p. 23).

Gamino and Ritter (2012) developed the term “death competence” (p. 23) to describe the specialized skills necessary for working with individuals who are terminally ill or bereaved. In order to have a high level of competence, practitioners must possess both emotional and cognitive competencies. Emotional competence refers to a psychologist’s ability to avoid vicarious traumatization (Gamino & Ritter, 2012). This is a skill that is taught in many psychologist training programs (Sommer, 2008) and should be reinforced for individuals working with end-of-life concerns.

Cognitive competence refers to the knowledge gained by practitioners through training and supervision (Gamino & Ritter, 2012). In working with people at the end of life, cognitive competence involves the possession of medical and administrative knowledge, as well as the knowledge of appropriate interventions (Kasl-Godley et al., 2014; Haley et al., 2003). Medical knowledge, according to Kasl-Godley et al. (2014), involves an understanding of the course, symptoms, and physical and emotional changes that occur across the illness. In addition, medical knowledge involves a basic understanding of symptom management, which is essential for effective treatment planning (Kasl-Godley et al., 2014). Administrative knowledge, according to Haley et al. (2003), involves an understanding of end-of-life documentation (e.g., an advance

directive). Psychologists who possess this type of knowledge may be better able to assist their clients as they progress through illness (Haley et al., 2003). An understanding of appropriate interventions, according to Kasl-Godley et al. (2014), is important because it allows psychologists to be able to implement effective and personalized treatments.

Utilizing these skills provide terminally ill and bereaved individuals with the best possible care through evidenced-based treatments and interventions (Kasl-Godley et al., 2014).

In accordance with population aging (Statistics Canada, 2010) and the projected increase in chronic illness (World Health Organization, 2005), psychologists need to possess both the emotional and cognitive domains of death competency. The development of training programs will enable therapists to develop proficiency in these domains and be better able to assist individuals from this population. Currently, nearly 35% of surveyed psychologists do not believe that they are competent in working with individuals at the end of life. Specifically, this thesis found that many do not possess the confidence to assess competency in individuals who are terminally ill. Through training and supervision, this trend can be changed and psychologists will be better able to work with the terminally ill and advocate for their best interests. According to the Canadian Psychological Association (2000), this level of training is considered to be an ethical imperative.

Ethical practice. Despite an exhaustive search of Google Scholar as well as the EBSCO, ProQuest, and Ovid databases, no practice standards exist for psychologists working with individuals who request assistance in dying. In addition, the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000) does not

specifically address issues surrounding end-of-life care. In Chapter 2, the many ethical issues relevant to psychologists were discussed. In the previous section, the need for training was explored. Future research, policy, and professional development should recognize the increasing need for psychologists to possess guidance in this area. In addition to training, practice standards need to be created in order to guide these professionals in ethical, and consistent, practice.

A feminist bioethics approach to best practice. Psychologists, through integrating the practice of feminist bioethics, may be able to develop standards that reflect best practice for the patient, psychologist, and general public. These standards would represent a respect for autonomy, which is an important focal point in feminist bioethics (Boetzkes, 1999; Sherwin, 1998) and the ethical practice for psychologists (Canadian Psychological Association, 2000). Autonomy, in this context, refers to the client's ability to resist oppressive forces and develop personally beneficial options (Sherwin, 1998). This is in contrast to agency, in which a person is only able to make a reasonable choice (Sherwin, 1998).

In order to promote autonomy rather than agency, psychologists should consider many factors in working with a terminally ill client. According to Sherwin (1998), individual factors as well as the circumstances surrounding the decision must be considered when making an autonomous choice. In addition, a practitioner must understand how the self is relational and therefore shaped by the social, cultural, and political factors that surround the individual. By understanding how these factors shape an individual and his or her decisions, the oppressive forces (e.g., the expert stance of the healthcare system) can be made explicit and removed from the treatment decision

(Sherwin, 1998). An understanding of these forces can also aid in provision of effective treatment for individuals with terminal illness. According to Sherwin (1998), practice exercising autonomy in a supportive environment can enable a person to make choices that are consistent with his or her own values.

In addition to providing a lens from which to understand the terminally ill client, feminist bioethics provides a method of understanding the oppression that exists in the healthcare system. In previous sections, the referenced oppression has focused solely on hospital administration and medical doctors. However, psychologists are part of this oppression and should be aware of their potential to impede autonomy. According to Ord (2009), mental health professionals diagnose clients in ways that reinforce their expert role. For example, a normal client response (e.g., bereavement) is pathologized (e.g., complicated grief) in a way that suits the clinician's interests. In order to remedy this, clients and professionals alike must exercise autonomy and "ask critical questions, disrupt the rational, and challenge the ways in which [society] has been taught to 'know'" (Ord, 2009, p. 201). Psychologists, by being asked to consider the dominant discourse of their expertise, may be able to challenge their views and provide better service to individuals at the end of life. Rather than being comparable to medical professionals who reinforce their expert status (Sherwin, 1998), psychologists may help the client exert autonomy by exercising autonomy themselves (Ord, 2009). The inclusion of feminist bioethics may be a very important step in providing effective end-of-life care. Future standards should focus on the principles of decision making, autonomy, and expertise in providing direction to psychologists.

Conclusion

This thesis provides more than a significant contribution to the assisted death literature; it is the evidence of a thesis student's personal and professional journey. Through exploring and critically analyzing the state of the euthanasia debate, the researcher has found how important it is for psychologists to be knowledgeable about social issues. Through being knowledgeable and respecting the client's independence, psychologists should be able to advocate for patient rights in the face of a paternalistic medical system, assist clients in making decisions that are consistent with their values, and support clients if the decision they make is to receive assistance in dying. This is consistent with the principles of feminist bioethics and the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association, 2000). This is also the manner that the researcher, as a future psychologist, wishes to practice. Overall, this thesis has left the researcher with a new appreciation for psychologist's role in the assisted death debate. Assisted death is a complex issue embedded with moral, ethical, and legal dilemmas. Through including psychologists in the discussion, this debate can remain focused on the most important individuals, the terminally ill clients.

References

- Anderson, S. C., & Guyton, M. R. (2013). Ethics in an age of information seekers: A survey of licensed healthcare providers about online social networking. *Journal of Technology in Human Services, 31*, 112–128.
doi:10.1080/15228835.2013.775901
- Angus Reid Global. (2010). *Two-thirds of Canadians express support for legalizing euthanasia*. Retrieved from http://www.angusreidglobal.com/wp-content/uploads/2010/02/2010.02.15_Euthanasia_CAN.pdf
- Baxter v. Montana, SCM DA 09–0051 (December 31, 2009).
- Beauchamp, T. L. (1996). Introduction. In T. L. Beauchamp (Ed.), *Intending death: The ethics of assisted suicide and euthanasia* (pp. 1–22). Upper Saddle River, NJ: Prentice Hall.
- Bill 52: An Act Respecting End of Life Care*. (2014). 41st Parliament, 1st Session.
Retrieved from <http://www.publicationsduquebec.gouv.qc.ca/eng/products/61580>
- Blendon, R. J., Schoen, C., DesRoches, C. M., Osborn, R., Scoles, K. L., & Zapert, K. (2002). Inequities In health care: A five-country survey. *Health Affairs, 21*, 182–191. doi:10.1377/hlthaff.21.3.182
- Blondeau, D., Roy, L., Dumont, S., Godin, G., & Martineau, I. (2005). Physicians' and pharmacists' attitudes toward the use of sedation at the end of life: Influence of prognosis and type of suffering. *Journal of Palliative Care, 21*, 238–245.
- Boetzkes, E. (1999). Equality, autonomy, and feminist bioethics. In A. Dondin & L. M. Purdy (Eds.), *Embodying bioethics: Recent feminist advances* (pp. 121–139). Lanham, MD: Rowman & Littlefield.

- Bravo, G., Dubois, M. F., Cohen, C., Wildeman, S., Graham, J., Painter, K., & Bellemare, S. (2011). Are Canadians providing advance directives about health care and research participation in the event of decisional incapacity? *Canadian Journal of Psychiatry*, 56, 209–218.
- Butler, M., Tiedemann, M., Nicol, J., & Valiquet, D. (2013). *Euthanasia and assisted suicide in Canada* (Publication No. 2010-68-E). Retrieved from <http://www.parl.gc.ca/Content/LOP/ResearchPublications/2010-68-e.htm>
- Canadian Charter of Rights and Freedoms, s. 2, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11. Retrieved from http://www.canlii.org/en/ca/laws/stat/schedule-b-to-the-canada-act-1982-uk-1982-c-11/latest/schedule-b-to-the-canada-act-1982-uk-1982-c-11.html#PART_I_CANADIAN_CHARTER_OF_RIGHTS_AND_FREEDOMS_554
- Canadian Medical Association. (2004). *CMA policy: CMA code of ethics*. Retrieved from <http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD04-06.pdf>
- Canadian Medical Association. (2007). *CMA policy: Euthanasia and assisted suicide (update 2007)*. Retrieved from <http://policybase.cma.ca/dbtw-wpd/Polycypdf/PD07-01.pdf>
- Canadian Psychological Association. (2000). *Canadian code of ethics for psychologists* (3rd ed.). Retrieved from http://www.cpa.ca/docs/File/Ethics/cpa_code_2000_eng_jp_jan2014.pdf

- Canadian Psychological Association. (2013, June). *Annual report 2012–2013*. Retrieved from
<http://www.cpa.ca/docs/File/Governance/2013Convention/AnnualReport2013FINAL.pdf>
- Canadian Psychological Association. (2014a). *CPA news*. Retrieved from
<http://www.cpa.ca/membership/membershipbenefitsandservices/CPANews/#>
- Canadian Psychological Association. (2014b). *Recruit research participants portal*.
 Retrieved from <https://web.cpa.ca/r2p2/>
- Carter v. Canada, BCSC 886 (2012, June 6).
- Carter v. Canada, SCC 5 (2015, February 6).
- Catt, S., Blanchard, M., Addington-Hall, J., Zis, M., Blizard, R., & King, M. (2005).
 Older adults' attitudes to death, palliative treatment and hospice care. *Palliative Medicine*, 19, 402–410. doi:10.1191/0269216305pm1037oa
- Chambaere, K., Bilsen, J., Cohen, J., Onwuteaka-Philipsen, B., Mortier, F., & Deliens, L. (2010). Physician-assisted deaths under the euthanasia law in Belgium: A population-based survey. *Canadian Medical Association Journal*, 182, 895–901. doi:10.1503/cmaj.091876
- College of Alberta Psychologists. (2013). *Criteria for evaluating academic credentials for registration as a psychologist in Alberta*. Retrieved from
<http://cap.ab.ca/pdfs/criteriaforevaluatingacademiccredentials201305.pdf>

- Concato, J., Peduzzi, P., Holdford, T. R., & Feinstein, A. R. (1995). Importance of events per independent variable in proportional hazards analysis I: Background, goals, and general strategy. *Journal of Clinical Epidemiology*, 48, 1495–1501. doi:10.1016/0895-4356(95)00510-2
- Cormack, M. (2000). Euthanasia and assisted suicide in the post-Rodriguez era: Lessons from foreign jurisdictions. *Osgoode Hall Law Journal*, 38(4), 591–641.
- Criminal Code, RSC 1985, c C-46. Retrieved from <http://www.canlii.org/en/ca/laws/stat/rsc-1985-c-c-46/latest/rsc-1985-c-c-46.html>
- Crowhurst, B., & Dobson, K. S. (1993). Informed consent: Legal issues and applications to clinical practice. *Canadian Psychology*, 34(3), 329–346. doi:10.1037/h0078838
- Curtis, C. (2013, August 27). Quebec v feds on the right to die. *Montreal Gazette*. Retrieved from <http://www.dyingwithdignity.ca/2013/08/27/quebec-v-feds-on-the-right-to-die.php>
- de Boer, M. E., Dröes, R.-M., Jonker, C., Eefsting, J. A., & Hertogh, C. M. P. M. (2011). Advance directives for euthanasia in dementia: How do they affect resident care in Dutch nursing homes? Experiences of physicians and relatives. *Journal of the American Geriatric Society*, 59, 989–996. doi:10.1111/j.1532-5415.2011.03414.x
- Denning, K. H., Jones, L., & Sampson, E. L. (2013). Preferences for end-of-life care: A nominal group study of people with dementia and their family carers. *Palliative Medicine*, 27, 409–417. doi:10.1177/0269216312464094

Dougherty, K. (2014, June 6). Bill 52 on end-of-life care adopted in National Assembly.

Montreal Gazette. Retrieved from

<http://www.montrealgazette.com/health/Bill+life+care+adopted+National+Assembly/9911814/story.html>

Downie, J. (2004). *Dying justice: A case for decriminalizing euthanasia & assisted suicide*. Toronto, ON, Canada: University of Toronto Press.

Ebrahimi, N. (2012). The ethics of euthanasia. *Australian Medical Student Journal*, 3(1), 73–76. Retrieved from <http://www.amsj.org/archives/2066>

Eckholm, E. (2014, January 13). New Mexico judge affirms right to ‘aid in dying.’ *The New York Times*. Retrieved from http://www.nytimes.com/2014/01/14/us/new-mexico-judge-affirms-right-to-aid-in-dying.html?_r=0

Eggertson, L. (2013). CMA delegates defer call for national discussion of medically assisted death. *Canadian Medical Association Journal*, 185, 623–624. doi:10.1503/cmaj.109-4587

Elliott, J. A., & Olver, I. N. (2008). Dying cancer patients talk about euthanasia. *Social Science & Medicine*, 67, 647–656. doi:10.1016/j.socscimed.2008.04.004

Elmslie, K. (2014). *Against the growing burden of disease* [Slideshow presentation]. Retrieved from <http://www.ccgh-csih.ca/assets/Elmslie.pdf>

Emanuel, E. J. (2002). Euthanasia and physician-assisted suicide: A review of the empirical data from the United States. *Archives of Internal Medicine*, 162, 142–152. doi:10.1001/archinte.162.2.142

Facebook. (2015). *Connect with friends and the world around you on Facebook* [social networking software]. Retrieved from <https://www.facebook.com/>

- Fadem, P., Minkler, M., Perry, M., Blum, K., Moore, L. F., Jr., Rogers, J., & Williams, L. (2003). Attitudes of people with disabilities toward physician-assisted suicide legislation: Broadening the dialogue. In M. Stingl (Ed.), *The price of compassion: Assisted suicide and euthanasia* (pp. 247–242). Peterborough, ON, Canada: Broadview Press.
- Fohr, S. A. (1998). The double effect of pain medication: Separating myth from reality. *Journal of Palliative Medicine, 1*, 315–328. doi:10.1089/jpm.1998.1.315
- Galbraith, K. M., & Dobson, K. S. (2000). The role of the psychologist in determining competence for assisted suicide/euthanasia in the terminally ill. *Canadian Psychology, 41*, 174–183.
- Gall, M. D., Gall, J. P., & Borg, W. R. (2007). *Educational research: An introduction* (8th ed.). Boston, MA: Pearson.
- Gamino, L. A., & Ritter, R. H., Jr. (2012). Death competence: An ethical imperative. *Death Studies, 36*, 23–40. doi:10.1080/07481187.2011.553503
- Gamliel, E. (2013). To end life or not to prolong life: The effect of message framing on attitudes toward euthanasia. *Journal of Health Psychology, 18*, 693–703. doi:10.1177/1359105312455078
- Gastmans, C., & de Lepeleire, J. (2010). Living to the bitter end? A personalist approach to euthanasia in persons with severe dementia. *Bioethics, 24*, 78–86. doi:10.1111/j.1467-8519.2008.00708.x

- Georges, J.-J., Onwuteaka-Philipsen, B. J., Muller, M. T., van der Wal, G., van der Heide, A., & van der Maas, P. J. (2007). Relatives' perspective on the terminally ill patients who died after euthanasia or physician-assisted suicide: A retrospective cross-sectional interview study in the Netherlands. *Death Studies*, 31, 1–15. doi:10.1080/07481180600985041
- Gevers, S., & Legemaate, J. (1998). Physician-assisted suicide in psychiatry: An analysis of case law and professional opinions. In D. C. Thomasma, T. Kimbrough-Kushner, G. K. Kimsma, & C. Ciesielski-Carlucci (Eds.), *Asking to die: Inside the Dutch debate about euthanasia* (pp. 71–91). Dordrecht, The Netherlands: Kluwer Academic.
- Givens, J. L., & Mitchell, S. L. (2009). Concerns about end-of-life care and support for euthanasia. *Journal of Pain and Symptom Management*, 38, 167–173. doi:10.1016/j.jpainsymman.2008.08.012
- Goodman, L.-A. (2014, August 19). Doctors debate end-of-life care at Canadian Medical Association meeting. *CBC News Toronto*. Retrieved from <http://www.cbc.ca/news/canada/toronto/doctors-debate-end-of-life-care-at-canadian-medical-association-meeting-1.2740904>
- Hadjistavropoulos, T. (1996). The systematic application of ethical codes in the counseling of persons who are considering euthanasia. *The Journal of Social Issues*, 52, 169–188. doi:10.1111/j.1540-4560.1996.tb01574.x

- Haley, W. E., Larson, D. G., Kasl-Godley, J., Neimeyer, R. A., & Kwilosz, D. M. (2003). Roles for psychologists in end-of-life care: Emerging models of practice. *Professional Psychology: Research and Practice*, 34, 626–633.
doi:10.1037/0735-7028.34.6.626
- Hamedy, S. (2014, January 19). New Mexico judge affirms right to ‘aid in dying.’ *Los Angeles Times*. Retrieved from <http://www.latimes.com/nation/la-na-new-mexico-aid-dying-20140120,0,6431747.story#ixzz2r003xOVc>
- Hanna, D., & Dempster, M. (2012). *Psychology statistics for dummies*. Hoboken, NJ: John Wiley & Sons.
- Henderson, H. (2008, February 29). Latimer ruling ‘slippery slope,’ disabled say. *Toronto Star*. Retrieved from http://www.thestar.com/news/canada/2008/02/29/latimer_ruling_slippery_slope_disabled_say.html
- Hertogh, C. M. P. M., de Boer, M. E., Dröes, R.-M., & Eefsting, J. A. (2007). Would we rather lose our life than lose our self? Lessons from the Dutch debate on euthanasia for patients with dementia. *The American Journal of Bioethics*, 7(4), 48–56. doi:10.1080/15265160701220881
- Johansen, S., Hølen, J. C., Kaasa, S., Loge, J. H., & Materstvedt, L. J. (2005). Attitudes towards, and wishes for, euthanasia in advanced cancer patients at a palliative medicine unit. *Palliative Medicine*, 19, 454–460.
doi:10.1191/0269216305pm1048oa

- Karlsson, M., Milberg, A., & Strang, P. (2012). Dying cancer patients' own opinions on euthanasia: An expression of autonomy? A qualitative study. *Palliative Medicine*, 26, 34–42. doi:10.1177/0269216311404275
- Kasl-Godley, J. E., King, D. A., & Quill, T. E. (2014). Opportunities for psychologists in palliative care: Working with patients and families across the disease continuum. *American Psychologist*, 69, 364–376. doi:10.1037/a0036735
- Kennedy, M. (2013, November 3). Stephen Harper's conservative party tilts right while he faces slow-burning scandal. *National Post*. Retrieved from <http://news.nationalpost.com/2013/11/03/stephen-harpers-conservative-party-tilts-right-while-he-faces-slow-burning-scandal/>
- Legemaate, J. (2004). The Dutch Euthanasia Act and related issues. *Journal of Law and Medicine*, 11, 312–323.
- Lemmens, T., & Dickens, B. (2001). Canadian law on euthanasia: Contrasts and comparisons. *European Journal of Health Law*, 8, 135–155.
doi:10.1163/15718090120523466
- Levy, T. B., Azar, S., Huberfeld, R., Siegel, A. M., & Strous, R. D. (2013). Attitudes towards euthanasia and assisted suicide: A comparison between psychiatrists and other physicians. *Bioethics*, 27, 402–408. doi:10.1111/j.1467-8519.2012.01968.x
- Maioni, A. (2014, January 1). Obamacare vs. Canada: Five key differences. *Globe and Mail*. Retrieved from <http://www.theglobeandmail.com/globe-debate/obamacare-vs-canada-five-key-differences/article14657740/>

- Marcoux, I., Mishara, B. L., & Durand, C. (2007). Confusion between euthanasia and other end-of-life decisions: Influences on public opinion poll results. *Canadian Journal of Public Health*, 98, 235–239.
- Marcoux, I., Onwuteaka-Philipsen, B. D., Jansen-van der Weide, M. C., & van der Wal, G. (2005). Withdrawing an explicit request for euthanasia and physician-assisted suicide: A retrospective study on the influence of mental health status and other patient characteristics. *Psychological Medicine*, 35, 1265–1275.
doi:10.1017/S0033291705005465
- McCormack, R., Clifford, M., & Conroy, M. (2012). Attitudes of UK doctors towards euthanasia and physician-assisted suicide: A systematic literature review. *Palliative Medicine*, 26, 23–33. doi:10.1177/0269216310397688
- McDonald-Gibson, C. (2014, February 13). Belgium extends euthanasia law to kids. *Time*. Retrieved from <http://world.time.com/2014/02/13/belgium-euthanasia-law-children-assisted-suicide/>
- Meichenbaum, D. (2005). 35 years of working with suicidal patients: Lessons learned. *Canadian Psychology*, 46, 64–72. doi:10.1037/h0087006
- Meier, D. E., Emmons, C.-A., Wallenstein, S., Quill, T., Morrison, R. S., & Cassel, C. K. (1998). A national survey of physician-assisted suicide and euthanasia in the United States. *The New England Journal of Medicine*, 338, 1193–1201.
doi:10.1056/NEJM199804233381706
- Mendelson, D., & Jost, T. S. (2003). A comparative study of the law of palliative care and end-of-life treatment. *The Journal of Law, Medicine & Ethics*, 31, 130–143.
doi:10.1111/j.1748-720X.2003.tb00063.x

- Menzel, P. T., & Steinbock, B. (2013). Advance directives, dementia, and physician-assisted death. *Journal of Law, Medicine, & Ethics*, 41, 484–500.
doi:10.1111/jlme.12057
- Moulton, B. E., Hill, T. D., & Burdette, A. (2006). Religion and trends in euthanasia attitudes among U.S. adults, 1977–2004. *Sociological Forum*, 21, 249–272.
doi:10.1007/s11206-006-9015-5
- New York State Task Force on Life and the Law. (1994). *When death is sought: Assisted suicide and euthanasia in the medical context*. Retrieved from
http://www.health.ny.gov/regulations/task_force/reports_publications/when_death_is_sought/
- Niederjohn, D. M., & Rogers, D. T. (2009). Objectivity in evaluations for assisted suicide: Appreciating the role of relational and intrapsychic components. *Journal of Forensic Psychology Practice*, 9, 70–81. doi:10.1080/15228930802427114
- Ord, R. L. (2009). “It’s like a tattoo”: Rethinking dominant discourses on grief. *Canadian Social Work Review*, 26, 195–211.
- Oregon Public Health Division. (2013). *Oregon’s Death with Dignity Act--2012*. Retrieved from
<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year15.pdf>
- Orr, R. D. (2001). Pain management rather than assisted suicide: The ethical high ground. *Pain Medicine*, 2, 131–137. doi:10.1046/j.1526-4637.2001.002002131.x

Parpa, E., Mystakidou, K., Tsilika, E., Sakkas, P., Patiraki, E., Pisteveu-Gombaki, K., . . .

Gouliamos, A. (2010). Attitudes of health care professionals, relatives of advanced cancer patients and public towards euthanasia and physician-assisted suicide. *Health Policy*, 97, 160–165. doi:10.1016/j.healthpol.2010.04.008

People of the State of Michigan v. Jack Kevorkian, 2001 OCC 221758 (July 23, 1999).

Quebec specialists support legalizing euthanasia. (2009, October 13). *CBC News*.

Retrieved from <http://www.cbc.ca/news/canada/montreal/quebec-specialists-support-legalizing-euthanasia-1.852113>

R. v. Latimer (1995), 126 D.L.R. (4th) 2013 (Sask. C.A.)

Rachels, J. (1994). More impertinent distinctions and a defense of active euthanasia. In B.

Steinbock & A. Lorcross (Eds.), *Killing and letting die* (pp. 139-154). New York, NY: Fordham University Press

Regionale Toetsingscommissies Euthansie. (2012). *Jaarverslag 2012*. Retrieved from

http://www.euthanasiecommissie.nl/Images/JV_RTE2012_WEB_DEF_tcm52-37320.pdf

Robiner, W. N., Tumlin, T. R., & Tompkins, T. L. (2013). Psychologists and medications

in the era of interpersonal care: Collaboration is less problematic and costly than prescribing. *Clinical Psychology: Science and Practice*, 20, 489–507.

doi:10.1111/cpsp.12054

Rodriguez v. British Columbia, 1993 3 S.C.R. 519 (August 30, 1993).

- Rurup, M. L., Onwuteaka-Philipsen, B. D., van der Heide, A., van der Wal, & van der Maas, P. J. (2005). Physicians' experiences with demented patients with advance euthanasia directives in the Netherlands. *Journal of the American Geriatrics Society*, 53, 1138–1144. doi:10.1111/j.1532-5415.2005.53354.x
- Rurup, M. L., Smets, T., Cohen, J., Bilson, J., Onwuteaka-Philipsen, B. D., & Deliens, L. (2011). The first five years of euthanasia legislation in Belgium and the Netherlands: Description and comparison of cases. *Palliative Medicine*, 26, 43–49. doi:10.1177/0269216311413836
- Sadler, K. (2012). Palliative sedation to alleviate existential suffering at end-of-life: Insight into a controversial practice. *Canadian Oncology Nursing Journal*, 22, 195–199. doi:10.5737/1181912x223195199
- Sauermann, H., & Roach, M. (2013). Increasing web survey response rates in innovation research: An experimental study of static and dynamic contact design features. *Research Policy*, 42, 273–286. doi:10.1016/j.respol.2012.05.003
- Schroder, C., Heyland, D., Jiang, X., Rocker, G., & Dodek, P. (2009). Educating medical residents in end-of-life care: Insights from a multicenter survey. *Journal of Palliative Medicine*, 12, 459–470. doi:10.1089/jpm.2008.0280
- Schüklenk, U., van Delden, J. J. M., Downie, J., McLean, S. A. M., Upshur, R., & Weinstock, D. (2011). End-of-life decision-making in Canada: The report by the Royal Society of Canada expert panel on end-of-life decision-making. *Bioethics*, 25(issue supplement s1), 1–73. doi:10.1111/j.1467-8519.2011.01939.x

- Shariff, M. J. (2012). Assisted death and the slippery slope—finding clarity amid advocacy, convergence, and complexity. *Current Oncology*, 19, 143–154.
doi:10.3747/co.19.1095
- Sherwin, S. (1992). *No longer patient: Feminist ethics & health care*. Philadelphia, PA: Temple University Press.
- Sherwin, S. (1998). *The politics of women's health: Exploring agency and autonomy*. Philadelphia, PA: Temple University Press.
- Sherwin, S. (2001). Feminist ethics and the metaphor of AIDS. *Journal of Medicine and Philosophy*, 26, 343–364. doi:10.1076/jmep.26.4.343.3011
- Somerville, M. (2001). *Death talk: The case against euthanasia and physician-assisted suicide*. Montreal, QC, Canada: McGill-Queen's University Press.
- Sommer, C. A. (2008). Vicarious traumatization, trauma-sensitive supervision, and counselor preparation. *Counselor Education and Supervision*, 48, 61–71.
doi:10.1002/j.1556-6978.2008.tb00062.x
- Statistics Canada. (2010, June). *Population projections for Canada, provinces and territories: 2009 to 2036* (Cat. No. 91-520-X). Retrieved from
<http://www.statcan.gc.ca/pub/91-520-x/91-520-x2010001-eng.pdf>
- Statistics Netherlands. (2012). *Deaths by medical end-of-life decision; age, cause of death*. Retrieved from
<http://statline.cbs.nl/StatWeb/publication/?VW=T&DM=SLen&PA=81655ENG&LA=en>
- Stingl, M. (2010a). Introduction. In M. Stingl (Ed.), *The price of compassion: Assisted suicide and euthanasia* (pp. 1–19). Peterborough, ON, Canada: Broadview Press.

- Stingl, M. (2010b). Voluntary and nonvoluntary euthanasia: Is there really a slippery slope? In M. Stingl (Ed.), *The price of compassion: Assisted suicide and euthanasia* (pp. 141–158). Peterborough, ON, Canada: Broadview Press.
- Sumner, L. W. (2011). *Assisted death: A study in ethics and law*. New York, NY: Oxford University Press.
- SurveyMonkey. (2015). *Online surveys in Canada* [Canadian-hosted online survey software]. Retrieved from <https://www.surveymonkey.com/mp/global/canada/>
- Taylor, L., McMinn, M. R., Bufford, R. K., & Chang, K. B. T. (2010). Psychologists' attitudes and ethical concerns regarding the use of social networking web sites. *Professional Psychology: Research and Practice*, 41, 153–159.
doi:10.1037/a0017996
- Taylor, M. L. (2001). Ethical issues for psychologists in pain management. *Pain Medicine*, 2, 147–154. doi:10.1046/j.1526-4637.2001.002002147.x
- Televantos, A., Talias, M. A., Charalambous, M., & Soteriades, E. S. (2013). Attitudes towards euthanasia in severely ill and dementia patients and cremation in Cyprus: A population-based survey. *BMC Public Health*, 13, 878–884. doi:10.1186/1471-2458-13-878
- Tulloch, G. (2005). *Euthanasia: Choice and death*. Edinburgh, Scotland: Edinburgh University Press.
- Tymchuk, A. J. (1997). Informing for consent: Concepts and methods. *Canadian Psychology*, 38, 55–75. doi:10.1037/0708-5591.38.2.55

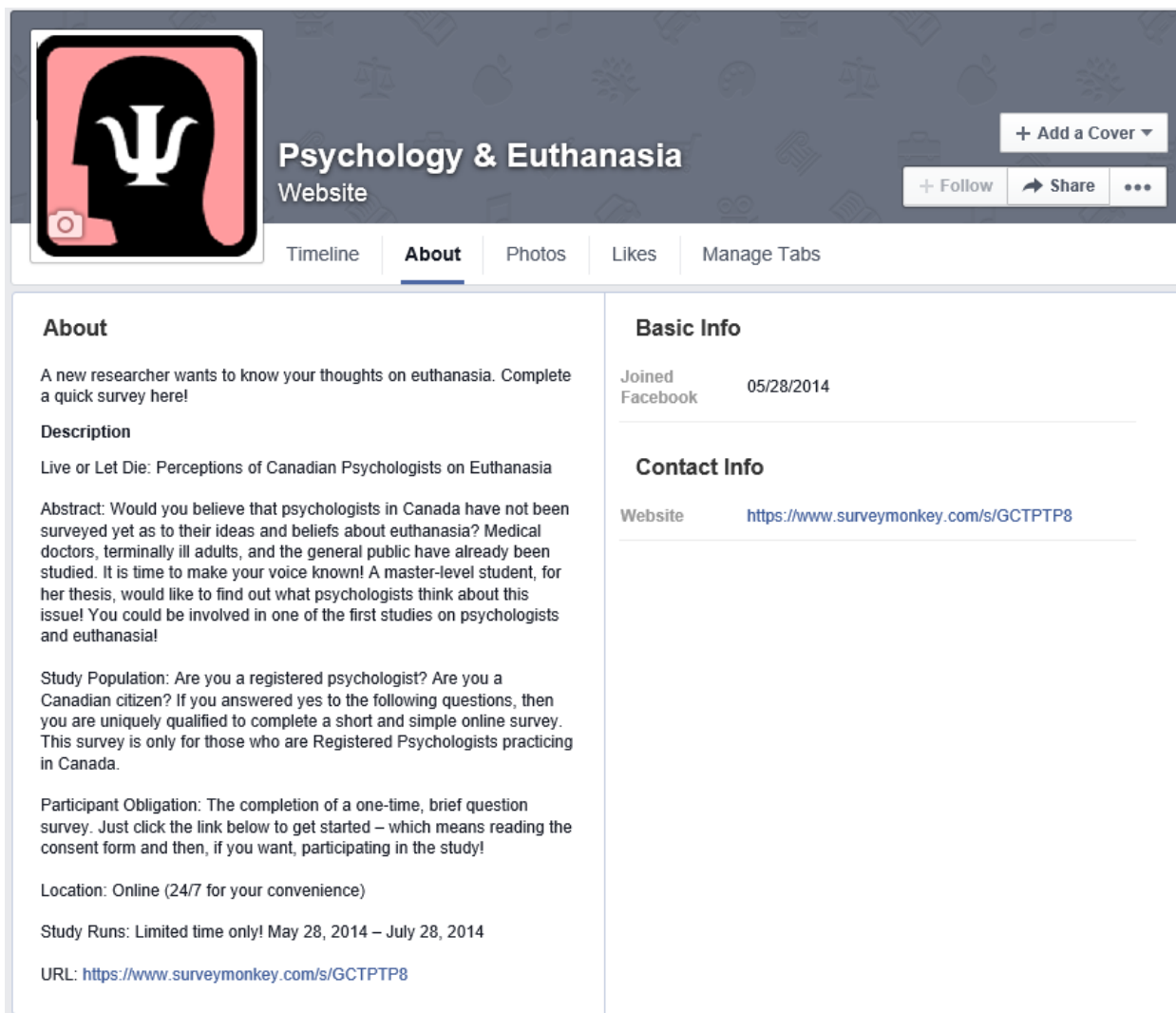
- Vamos, M. J. (2012). Physician-assisted suicide: Saying what we mean and meaning what we say. *The Australian and New Zealand Journal of Psychiatry*, 46, 84–86. doi:10.1177/0004867411432069
- van den Beuken-van Everdingen, M. H. J., de Rijke, J. M., Kessels, A. G., Schouten, H. C., van Kleef, M., & Patjin, J. (2007). Prevalence of pain in patients with cancer: A systematic review of the past 40 years. *Annals of Oncology*, 18, 1417–1449. doi:10.1093/annonc/mdm056
- van der Lee, M. L., van der Bom, J. G., Swarte, N. B., Heintz, A. P. M., de Graeff, A., & van der Bout, J. (2005). Euthanasia and depression: A prospective cohort study among terminally ill cancer patients. *Journal of Clinical Oncology*, 23, 6607–6612. doi:10.1200/JCO.2005.14.308
- Van Hoey, M. (Performer). (2014). The medical and moral issues raised by euthanasia [Radio series episode]. In *The Current*. Retrieved from <http://www.cbc.ca/radio/thecurrent/jan-8-2014-1.2908831/the-medical-and-moral-issues-raised-by-euthanasia-1.2908834>
- Varelius, J. (2013). Voluntary euthanasia, physician-assisted suicide, and the right to do wrong. *HEC Forum*, 25, 229–243. doi:10.1007/s10730-013-9208-2
- Victory in Vermont. (2013). *Voice for Choice*, 31(3), 2, 4. Retrieved from http://www.dyingwithdignity.ca/database/files/library/DWD_58532_Sep13_Newsletter_Final.pdf
- Vogel, L. (2012). Line between acts and omissions blurred, euthanasia critics argue. *Canadian Medical Association Journal*, 184, 19–21. doi:10.1503/cmaj.109-4061

- Washington State Department of Health. (2012). *Washington State Department of Health 2012 Death with Dignity Act report: Executive summary* (DOH 422-109). Retrieved from <http://www.doh.wa.gov/portals/1/Documents/Pubs/422-109-DeathWithDignityAct2012.pdf>
- Werth, J. L., Jr., Lewis, M. M., & Richmond, J. M. (2009). Psychologists' involvement with terminally ill individuals who are making end-of-life decisions. *Journal of Forensic Psychology Practice*, 9, 82–91. doi:10.1080/15228930802427130
- Williams, N., Dunford, C., Knowles, A., & Warner, J. (2007). Public attitudes to life-sustaining treatments and euthanasia in dementia. *International Journal of Geriatric Psychiatry*, 22, 1229–1234. doi:10.1002/gps.1819
- Wilson, D. M., Birch, S., MacLeod, R., Dhanji, N., Osei-Waree, J., & Cohen, J. (2013). The public's viewpoint on the right to hastened death in Alberta, Canada: Findings from a population survey study. *Health & Social Care in the Community*, 21, 200–208. doi:10.1111/hsc.12007
- Wilson, K. G., Chochinov, H. M., McPherson, C. J., Skirko, M. G., Allard, P., Chary, S., . . . Clinch, J. J. (2007). Desire for euthanasia or physician-assisted suicide in palliative cancer care. *Health Psychology*, 26, 314–323. doi:10.1037/0278-6133.26.3.314
- Wilson, K. G., Curran, D., & McPherson, C. J. (2005). A burden to others: A common source of distress for the terminally ill. *Cognitive Behaviour Therapy*, 34, 115–123. doi:10.1080/16506070510008461

- Winograd, R. (2012). The balance between providing support, prolonging suffering, and promoting death: Ethical issues surrounding psychological treatment of a terminally ill client. *Ethics & Behavior*, 22, 44–59.
doi:10.1080/10508422.2012.638825
- World Health Organization. (2005). *The impact of chronic disease in Canada*. Retrieved from http://www.who.int/chp/chronic_disease_report/media/canada.pdf?ua=1
- Yaffe, B. (2008). A deadlock on dying: Euthanasia: A case of chronic indecision. *Alive: Canadian Journal of Health & Nutrition*, 307, 52–55.
- Yun, Y. H., Han, K. H., Park, S., Park, B. W., Cho, C.-H., Kim, S.-Y., . . . Chun, M. (2011). Attitudes of cancer patients, family caregivers, oncologists and members of the general public toward critical interventions at the end of life of terminally ill patients. *Canadian Medical Association Journal*, 183, E673–E679.
doi:10.1503/cmaj.110020

Appendix A: Facebook Advertisement

Homepage:



The image shows a Facebook profile page for a page named "Psychology & Euthanasia Website". The profile picture is a black silhouette of a head with a white Psi symbol (Ψ) inside, set against a red background. The cover photo is a dark blue-grey gradient with faint, repeating icons of various symbols like a scale, a brain, and a heart. The page has tabs for "Timeline", "About", "Photos", "Likes", and "Manage Tabs", with "About" currently selected. The "About" section is divided into two columns. The left column contains the "About" text, a "Description" section, and a "URL" at the bottom. The right column contains "Basic Info" (Joined Facebook: 05/28/2014) and "Contact Info" (Website: <https://www.surveymonkey.com/s/GCTPTP8>).

Psychology & Euthanasia Website

+ Add a Cover ▾

+ Follow Share ...

Timeline **About** Photos Likes Manage Tabs

About

A new researcher wants to know your thoughts on euthanasia. Complete a quick survey here!

Description

Live or Let Die: Perceptions of Canadian Psychologists on Euthanasia

Abstract: Would you believe that psychologists in Canada have not been surveyed yet as to their ideas and beliefs about euthanasia? Medical doctors, terminally ill adults, and the general public have already been studied. It is time to make your voice known! A master-level student, for her thesis, would like to find out what psychologists think about this issue! You could be involved in one of the first studies on psychologists and euthanasia!

Study Population: Are you a registered psychologist? Are you a Canadian citizen? If you answered yes to the following questions, then you are uniquely qualified to complete a short and simple online survey. This survey is only for those who are Registered Psychologists practicing in Canada.

Participant Obligation: The completion of a one-time, brief question survey. Just click the link below to get started – which means reading the consent form and then, if you want, participating in the study!

Location: Online (24/7 for your convenience)

Study Runs: Limited time only! May 28, 2014 – July 28, 2014

URL: <https://www.surveymonkey.com/s/GCTPTP8>

Basic Info

Joined Facebook 05/28/2014

Contact Info

Website <https://www.surveymonkey.com/s/GCTPTP8>

Short Advertisement:

**Psychology & Euthanasia**

Like Page

Sponsored · *

A new researcher wants to know your thoughts on euthanasia. Complete a quick survey here!



Psychology & Euthanasia

SURVEYMONKEY.COM

Like · Comment · Share

Appendix B: Canadian Psychological Association and Provincial/Territorial Association Advertisement

Title: Live or Let Die: Perceptions of Canadian Psychologists on Euthanasia

Abstract: Would you believe that psychologists in Canada have not been surveyed yet as to their ideas and beliefs about euthanasia? Medical doctors, terminally ill adults, and the general public have already been studied. It is time to make your voice known! A master-level student, for her thesis, would like to find out what psychologists think about this issue! You could be involved in one of the first studies on psychologists and euthanasia!

Researcher: Sarah Karesa

Study Population: Are you a registered psychologist? Are you a Canadian citizen? If you answered yes to the following questions, then you are uniquely qualified to complete a short online survey. This survey is only for registered psychologists practicing in Canada.

Participant Obligation: The completion of a one-time, brief, 32 question survey. Just click the link below to get started!

Location: Online-Lethbridge

Study Runs: May 28, 2014 to July 28, 2014

URL: <https://www.surveymonkey.com/s/GCTPTP8>

Appendix C: On Death and Dying Survey

Introduction

Directions:

- You always have the option to stop completing the survey. To end your participation, close your internet browser. Your answers will not be used as no data will be saved.
- If you exit from the survey by closing your web browser, you will lose all data and will need to start again.
- The survey will take approximately 10-20 minutes.
- There are 5 parts to the survey. Part I is designed to make sure you meet the necessary criteria to participate in this study.
- Once you provide an answer it cannot be changed.
- If you can, please answer all the questions but you always have the option to ignore/skip any question of your choice.

Thank you for wanting to share your opinion about euthanasia in Canada!

Now, let's start this survey.

Part I: Screening Information

***1. Do you currently identify yourself as a registered psychologist living somewhere in Canada?**

- ☐ Yes
☐ No

Part II: Demographic Information**2. What is your age, as of today?****3. What is your gender?**☐ Male☐ Female☐ Other (please specify)**4. What is your province of residence?****Demographic Information Continued****5. Which specialty do you professionally identify with? Select all that apply.**☐ Clinical Psychology☐ Counselling Psychology☐ Forensic Psychology☐ Child and Adolescent Psychology☐ School Psychology☐ Health Psychology☐ Organizational Psychology☐ Couples and Family Psychology☐ Research☐ Professor/Teaching☐ Supervision☐ Group Psychology☐ Other (please specify)**6. Which specialty do you professionally identify with the most?**

7. If you are currently working, where do you spend the majority of your time? Check all that apply.

- ☐ Private Practice
- ☐ Hospital
- ☐ Non-Profit Organization
- ☐ Correctional Facility
- ☐ Academic Setting
- ☐ Primary-Secondary Schools
- ☐ Other (please specify)

8. How long have you been practicing as a registered, and not provisional, psychologist?

The following demographic questions will explore briefly your beliefs and experiences surrounding the areas of religion and end-of-life decision making. Please answer honestly and to the best of your ability.

9. Would you consider yourself a religious or spiritual person?

- ☐ Yes
- ☐ No
- ☐ Not Sure

Demographic Information Continued

How much do you agree with the following statements?

10. Religious or spiritual beliefs, more often than not, guide how I think about moral and ethical issues.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. For the most part, I actively practice my religion or spirituality. For example, attending a religious service or involvement in a religious organization.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. I believe my religious or spiritual beliefs are helpful in considering my end-of-life decisions.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Demographic Information Continued

13. At any point in your career, regardless of being a Registered Psychologist, have you ever professionally supported someone who was dying of a terminal illness? This work can be paid or unpaid and must involve a terminally ill individual who is not a relative or friend.

- ☐ Yes
☐ No
☐ Not Sure

14. Have you ever, at any point in your life, personally supported someone who was dying of a terminal illness? This person could be a friend or a relative and you were not paid to provide support.

- ☐ Yes
☐ No
☐ Not Sure

15. Over the course of your career as a registered psychologist, approximately what percentage of your caseload has consisted of terminally ill clients? This includes those clients who may have consulted you about end-of-life issues due to someone close to them dying of a terminal illness. Please provide a numeric answer.

16. Over the course of your career as a registered psychologist, approximately what percentage of your caseload has consisted of clients who were suicidal? Please provide a numeric answer

Part III: Perceptions

The following two questions are going to examine your professional and personal opinions surrounding assistance in dying. Professional opinions are those that you hold as a registered psychologist. Personal opinions are those that you hold based on your beliefs and experiences. Please answer honestly and to the best of your ability.

17. Should dying, competent adults in Canada have the right to refuse life-saving medical treatment when they decide the costs of living outweigh the benefits to living?

	Yes, I believe every competent adult should have this right.	Yes, but I believe it should be allowed only in certain cases or situations.	No, I do not believe anyone should have this right.
What is your professional opinion, as a registered psychologist? This opinion can be the same or different from your personal opinion.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking off the psychologist hat, what is your personal opinion? This opinion can be the same or different from your professional opinion.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Perceptions Continued

18. Should dying, competent adults in Canada have the right to receive assistance in dying from the medical community if they so request it?

	Yes, I believe every competent adult should have this right.	Yes, but I believe it should be allowed only in certain cases or situations.	No, I do not believe anyone should have this right.
Putting the psychologist hat on:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What is your professional opinion, as a registered psychologist? This opinion can be the same or different from your personal opinion.			
Taking off the psychologist hat, what is your personal opinion? This opinion can be the same or different from your professional opinion.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Part IV: Knowledge

19. Based on your knowledge and without researching the answer, is this an example of euthanasia?

	Yes, this <u>is typically</u> an example of euthanasia	No, this <u>is not typically</u> an example of euthanasia	Not Sure
In Canada, a physician grants a dying person's request to be given a lethal injection because the person states s/he no longer wants to suffer. The physician gives the injection, which results in the person's death.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In Canada, at the request of the patient, a physician disconnects the machines that were keeping this person alive (e.g., an artificial lung). This ultimately results in the patient's death.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In Canada, a physician grants the request of a terminally ill individual to be given potentially lethal medication so that the patient may die by his or her own hand. The physician provides the person with the medication, the person takes it, and this results in the patient's death.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Part V: Competency

How much do you agree with the following statements?

20. I possess the training necessary, as a registered psychologist, to assess the competence of terminally ill adults who are pursuing life-shortening medical treatment (i.e., physician-assisted death).

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21. I am confident in my ability, as a registered psychologist, to assess the competency of terminally ill adults who are pursuing life-shortening medical treatment (i.e., physician-assisted death).

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. I think psychologists should receive training in the area of end-of-life issues, such as assessment, decision making, and working with the medical system.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Part VI: Vignettes

Vignette #1:

You are a Registered Psychologist in Canada– Your client: An 80 year old Canadian man you have been seeing for 3 years. He has inoperable stomach cancer that results in frequent hospitalizations. He is in need of constant care.

Mental Health Status: He is coherent, oriented to time and place, and without a cognitive disability. He is also fully aware of his medical condition and its implications as well as fully capable of communicating his wishes.

Issue: You have been working with this client for 3 years and a frequent theme of your sessions together is listening to him discuss how he is suffering tremendously from his condition. In your previous session, he tells you he does not want to continue living in the state he is in. He will be asking his doctor to assist him in dying. He wants you to support him in his decision to end his life and to communicate this to his doctor.

Based on Vignette #1, please answer the following questions.

23. As a registered psychologist, I would be willing to tell the doctor that I support the client's request to receive assistance in dying.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

24. As a registered psychologist, I would be able to stay neutral (i.e., not share my opinion) when helping the client identify the benefits and consequences of his decision to end his life?

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

25. If I was the client in this scenario, and had been suffering like he has for 3 years, I would ask for assistance in dying.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Vignette #1 Continued

For the following questions, assume that all aspects of the story are kept constant except the area that is being questioned. Only one part of the story should change

26. I would be willing, as a registered psychologist, to support my client's request to die by talking to his doctor even if he was 30 years old, instead of 80 years old.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

27. I would be willing, as a registered psychologist, to support my client's request to die by talking to his doctor even if there was a chance of meaningful improvement.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Up to this point, euthanasia has been discussed in the context of terminal illness. The next vignette will examine a non traditional form of the practice in which euthanasia is considered because of mental illness.

Vignettes Continued

Vignette #2

You are a registered psychologist working in Canada

Your client: A 65-year-old Canadian woman has been your regular client for 5 months. You are providing her with counselling. This client has been diagnosed with major depression for 30 years (diagnosis has been repeatedly confirmed over the decades).

Mental Health Status: Frequent depressive episodes characterized by a severely depressed mood, loss of pleasure in everyday activities, significant weight loss, and significant periods of psychosis. She is completely isolated from the outside world (has no friends, is estranged from her family, and is severely unable to function outside of her home). In the past, she has tried to kill herself many times and has a history of alcohol abuse. Previous clinical and medical attempts at treatment have failed for at least 3 decades.

Issue: In the session you had with her yesterday she articulated, with clarity and focus, how she is intensively suffering due to her major depression. You listened to her describe, in detail, that she no longer has the strength to continue to cope with her severe emotional suffering. She described her belief that her life is hopeless and that she cannot bear to live the rest of her life with this severe depression. She announced in the session that she asked for her doctor's medical assistance in ending her life. She asks you to support her decision to end her life and to communicate to her doctor that you support this client's request to end her life through physician assisted methods.

Based on Vignette #2, please answer the following questions.

28. As a registered psychologist, I would be willing to tell the doctor that I support the client's request to receive assistance in dying.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29. As a registered psychologist, I would be able to stay neutral (i.e., not share my opinion) when helping the client identify the benefits and consequences of her decision to end her life?

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

30. If I was the client in this scenario, and I had been suffering like she has for 30 years, I would ask for assistance in dying.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Vignette #2 Continued

For the following questions, assume that all aspects of the story are kept constant except the area that is being questioned. Only one part of the story should change.

31. I would be willing, as a registered psychologist, to support my client's request to die by talking to her doctor even if she was 30 years old, instead of 65 years old.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

32. I would be willing, as a registered psychologist, to support my clients request to die by talking to her doctor even if there was a chance of meaningful improvement.

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

THANK YOU PAGE (FOR COMPLETED SURVEYS)

If you would like to receive a summary of the results, which will be available August 2014, please email:

Sarah Karesa
M.Ed. Thesis Student, University of Lethbridge
[email address]

Dr. Dawn McBride, R.Psych
Thesis Supervisor, University of Lethbridge
[email address]

Please note: If you experience emotional upset as a result of this survey, please debrief with someone you trust or contact your local community distress line. These numbers can be found at <http://www.suicideprevention.ca/in-crisis-now/find-a-crisis-centre-now/>

Thank you for completing this survey!

DISQUALIFICATION PAGE (FOR THOSE WHO DID NOT QUALIFY FROM QUESTION 1)

Thank you for your interest this survey!

Based on your response to previous question you are not eligible to complete this questionnaire. Eligible participants are individuals who are registered psychologists and are practicing within Canada. If you have any concerns regarding this study please email:

Sarah Karesa
M.Ed. Thesis Student, University of Lethbridge
[email address]

Dr. Dawn McBride, R.Psych
Thesis Supervisor, University of Lethbridge
[email address]

Appendix D: Letter of Human Subject Research Approval

The
University of
Lethbridge

MEMORANDUM

TO: Sarah Karesa
FROM: Kerry Bernes
Date: May 12, 2014

RE: Human Subject Research Application: “Live or Let Die: Perceptions of Canadian Psychologists on Euthanasia”

The Faculty of Education Human Subject Committee has **approved** your HSR application. The approval adheres to the Tri-Council Policy Statement, published on the website

<http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/Default/>

Good luck with your research.

Kerry Bernes, Ph.D.
Chair Human Subject Committee
Faculty of Education

Cc: Graduate Studies
Dawn McBride, supervisor

Appendix E: Participant Consent Form



Welcome! You are being invited to participate in a research study entitled:

“Live or Let Die: Perceptions of Canadian Psychologists on Euthanasia.”

This research has been approved by University of Lethbridge Faculty of Education Human Subjects Research Committee (HSRC).

What is the purpose of this study?

Given the recent debates covered in the media about euthanasia, it is timely to ask Canadian psychologists about their opinions and knowledge on this practice and to discover what factors influence these perceptions.

Why is this research important?

This is the first time psychologists in Canada have been invited to share their views on this controversial practice. Research has been conducted on the perceptions of the public, the terminally ill, and doctors, but no research has been conducted on the perspectives of psychologists. As such, this research may offer a different perspective on the current debate on euthanasia.

Why am I being invited to participate?

You are being asked to participate in this study because you are a Canadian Registered Psychologist. You have been selected for this study through (a) the Canadian Psychological Association Research Portal (R²P²); (b) the Canadian Psychological Association’s newsletter, *CAP News*; (c) Facebook advertising, or (d) your provincial or territorial college of psychology.

What will I have to do?

It’s simple! If you agree to participate in this research, your participation will include the one-time completion of an online survey. This survey is available on SurveyMonkey and will remain open throughout May and June.

I am a very busy person. How long will this take?

The survey contains 32 questions and should approximately 10–20 minutes to complete. Participation in this study may cause you some inconvenience, including a loss of time accounted for by completing the study.

Are there any risks to participating?

Yes. This topic can be a sensitive issue that may arouse some discomfort during or after completion of the survey. In order to reduce the likelihood of this occurring I have: (a) few questions asking directly about euthanasia, and (b) survey questions that are designed to be neutral to the current euthanasia debate. If you experience emotional upset as a result of this survey, please debrief with someone you trust or contact your local community distress line. These numbers can be found at <http://www.suicideprevention.ca/in-crisis-now/find-a-crisis-centre-now/>

Are there any benefits to being in this study?

Yes! Your results will be used to provide researchers, policy-makers, and the general public with information that they can use to better understand euthanasia. You may even develop a greater understanding of the topic! In addition, the information that you provide will be used to create research opportunities in an area that has, until recently, not been well studied.

Do I have to participate?

Absolutely not! Your participation is completely voluntary. You may withdraw *at any time* without any consequences or need for explanation. Even if you are in the middle of the survey you can stop participating by closing the online survey. By not submitting the online survey you are indicating that you do not want to participate in the study. If you close your browser during the survey your data will not be collected by the researcher for use in later analysis. However, once you submit the online survey, the data cannot be removed and it will be impossible to withdraw the information you provided.

Will my identity be made known at any point in the research?

No! The online survey will collect no identifying information from you. This means that there is no way for the information you provide to be connected to you. In addition, the information you provide will be combined with that of other participants. This will ensure that only the researcher can see individual results.

How will my information be kept secure?

Once you submit your survey, your information will be stored on a secure SurveyMonkey account. Since SurveyMonkey is an American company, your data will be stored in the United States. It is, therefore, subject to being viewed by the American government if they deem it necessary. After the survey closes, the link to the survey will be permanently closed and all of the information will be downloaded onto an encrypted flash drive. Data will be stored in a secure filing cabinet that is only accessible to the researcher, her supervisor, and likely a statistician consultant. Your information will kept for a period of 7 years in this secure format. After this point the data will be removed from the flash

drive and physically destroyed. The online data will also be deleted off of SurveyMonkey, and its server, at this time.

How can people access the results of the study?

It is anticipated that the results of this study will be shared with others in the following ways. Results will be shared through the creation of a master's thesis and may be used in future comparison studies. In addition, the survey data will be published in various academic and professional association resources as well as discussed at conferences and other learning events.

What if I want to access the results of the study?

That would be great – just contact the researcher or her supervisor (contact information is below) any time after June 2014.

Who is the researcher?

This study is being conducted by Sarah Karesa. Sarah is a graduate student in the Faculty of Education (counselling psychology) at the University of Lethbridge. If you have any questions she can be contacted by email at [email address]. The study is being conducted under the supervision of Dr. Dawn McBride R.Psych: [email address].

What if I have concerns about the study?

In addition to being able to contact the researcher and the supervisor at the above email addresses, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Chair of the Faculty of Education Human Subjects Research Committee at the University of Lethbridge ([telephone number]).

How do I show the researchers that I read and agree with this consent form?

By completing the online survey you are indicating that you understand the above conditions, that you have had the opportunity to have your questions answered by the researchers, and that you consent to your participation in the study.

You may print and keep a copy of this consent form for your records.

Appendix F: Cross Tabulation for Psychologist Perceptions

Table F1

Frequency Distribution on the Perceptions of Assisted Death

		Support Voluntary Passive Euthanasia				Against Voluntary Passive Euthanasia				Support Assisted Death				Against Assisted Death			
		Professional		Personal		Professional		Personal		Professional		Personal		Professional		Personal	
Item		<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Gender																	
	Male	22	25.6	22	25.6	2	2.3	2	2.3	20	23.8	20	23.5	3	3.6	3	3.5
	Female	60	69.8	58	67.4	2	2.3	4	4.7	58	69.0	58	68.2	3	3.6	4	4.7
Age																	
	20-29	4	4.7	4	4.7	0	0.0	0	0.0	4	4.8	4	4.7	0	0.0	0	0.0
	30-39	15	17.4	15	17.4	0	0.0	0	0.0	14	16.7	15	17.6	0	0.0	0	0.0
	40-49	18	20.9	17	19.8	1	1.2	2	2.3	17	20.2	16	18.8	2	2.4	3	3.5
	50-59	20	23.3	19	22.1	1	1.2	2	2.3	19	22.6	19	22.4	2	2.4	2	2.4
	60+	25	29.1	25	29.1	2	2.3	2	2.3	24	28.6	24	28.2	2	2.4	2	2.4
Province																	
	BC	9	10.6	9	10.6	1	1.2	1	1.2	9	10.8	9	10.7	1	1.2	1	1.2
	MB	19	22.4	19	22.4	2	2.4	2	2.4	18	21.7	19	22.6	2	2.4	2	2.4
	NB	27	31.8	27	31.8	1	1.2	1	1.2	26	31.3	26	31.0	1	1.2	1	1.2
	NL	20	23.5	18	21.2	0	0.0	2	2.4	18	21.7	17	20.2	2	2.4	3	3.6
	PEI	6	7.1	6	7.1	0	0.0	0	0.0	6	7.2	6	7.1	0	0.0	0	0.0
Specialty																	
	Clinical	50	58.1	50	58.1	4	4.7	4	4.7	48	57.1	50	58.8	5	6.0	4	4.7
	Counselling	17	19.8	17	19.8	2	2.3	2	2.3	17	20.2	17	20.0	2	2.4	2	2.4
	Forensic	5	5.8	5	5.8	0	0.0	0	0.0	5	6.0	5	5.9	0	0.0	0	0.0
	Child/ Adolescent	15	17.4	14	16.3	0	0.0	1	1.2	15	17.9	14	16.5	0	0.0	1	1.2
	School	17	19.8	16	18.6	0	0.0	1	1.2	16	19.0	15	17.6	0	0.0	1	1.2

Item	Support Voluntary Passive Euthanasia				Against Voluntary Passive Euthanasia				Support Assisted Death				Against Assisted Death			
	Professional		Personal		Professional		Personal		Professional		Personal		Professional		Personal	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Health	22	25.6	22	25.6	1	1.2	1	1.2	22	26.2	22	25.9	1	1.2	1	1.2
Organizational	3	3.5	3	3.5	0	0.0	0	0.0	3	3.6	3	3.5	0	0.0	0	0.0
Couples/Family	12	14.0	12	14.0	0	0.0	0	0.0	12	14.3	12	14.1	0	0.0	0	0.0
Research	9	10.6	9	10.6	1	1.2	1	1.2	9	10.8	9	10.7	1	1.2	1	1.2
Professor/Teaching	15	17.4	15	17.4	1	1.2	1	1.2	14	16.7	14	16.5	2	2.4	2	2.4
Supervision	10	11.6	10	11.6	0	0.0	0	0.0	10	11.9	10	11.8	0	0.0	0	0.0
Group	6	7.0	6	7.0	0	0.0	0	0.0	6	7.1	6	7.1	0	0.0	0	0.0
Other	4	4.7	4	4.7	0	0.0	0	0.0	4	4.8	4	4.7	0	0.0	0	0.0
Practice																
Private	30	34.9	30	34.9	3	3.5	3	3.5	29	34.5	30	35.3	3	3.6	3	3.5
Hospital	19	22.1	19	22.1	1	1.2	1	1.2	18	21.4	19	22.4	2	2.4	1	1.2
Non-Profit	2	2.3	2	2.3	0	0.0	0	0.0	2	2.4	2	2.4	0	0.0	0	0.0
Correctional	4	4.7	4	4.7	0	0.0	0	0.0	4	4.8	4	4.7	0	0.0	0	0.0
Academic	14	16.3	14	16.3	1	1.2	1	1.2	13	15.5	13	15.3	2	2.4	2	2.4
School	11	12.8	10	11.6	0	0.0	1	1.2	10	11.9	9	10.6	0	0.0	1	1.2
Other	13	15.1	12	14.0	1	1.2	2	2.3	14	16.7	13	15.3	0	0.0	1	1.2
Practice Length																
0-4	14	16.5	14	16.5	0	0.0	0	0.0	13	15.7	13	15.5	1	1.2	1	1.2
5-9	22	25.9	22	25.9	1	1.2	1	1.2	19	22.9	20	23.8	2	2.4	2	2.4
10-14	12	14.1	11	12.9	2	2.4	3	3.5	13	15.7	12	14.3	1	1.2	2	2.4
15-19	11	12.9	11	12.9	0	0.0	0	0.0	11	13.3	11	13.1	0	0.0	0	0.0
20-24	8	9.4	7	8.2	0	0.0	1	1.2	7	8.4	7	8.3	1	1.2	1	1.2
25-29	7	8.2	7	8.2	0	0.0	0	0.0	7	8.4	7	8.3	0	0.0	0	0.0
30-34	2	2.4	2	2.4	1	1.2	1	1.2	2	2.4	2	2.4	1	1.2	1	1.2
35+	5	5.9	5	5.9	0	0.0	0	0.0	5	6.0	5	6.0	0	0.0	0	0.0

Item	Support Voluntary Passive Euthanasia				Against Voluntary Passive Euthanasia				Support Assisted Death				Against Assisted Death			
	Professional		Personal		Professional		Personal		Professional		Personal		Professional		Personal	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Religion																
Moral Guide																
Agree	18	34.0	16	30.2	3	5.7	5	9.4	18	34.0	16	30.2	3	5.7	5	9.4
Neither	16	30.2	16	30.2	0	0.0	0	0.0	16	30.2	16	30.2	0	0.0	0	0.0
Disagree	16	30.2	16	30.2	0	0.0	0	0.0	15	28.3	16	30.2	1	1.9	0	0.0
Involvement																
Agree	23	42.6	21	38.9	3	5.6	5	9.3	22	41.5	20	37.0	4	7.5	6	11.1
Neither	5	9.3	5	9.3	0	0.0	0	0.0	5	9.4	5	9.3	0	0.0	0	0.0
Disagree	23	42.6	23	42.6	0	0.0	0	0.0	21	39.6	23	42.6	1	1.9	0	0.0
End-of-Life																
Agree	33	60.0	31	56.4	3	5.5	5	9.1	30	55.6	30	54.5	5	9.3	6	10.9
Neither	15	27.3	15	27.3	0	0.0	0	0.0	15	27.8	15	27.3	0	0.0	0	0.0
Disagree	4	7.3	4	7.3	0	0.0	0	0.0	4	7.4	4	7.3	0	0.0	0	0.0
Support																
Professionally																
Yes	34	39.5	34	39.5	2	2.3	2	2.3	33	39.3	34	40.0	2	2.4	2	2.4
No	48	55.8	46	53.5	2	2.3	4	4.7	45	53.6	44	51.8	4	4.8	5	5.9
Personally																
Yes	48	56.5	47	55.3	3	3.5	4	4.7	47	56.6	47	56.0	3	3.6	3	3.6
No	32	37.6	31	36.5	1	1.2	2	2.4	29	34.9	29	34.5	3	3.6	4	4.8
Not Sure	1	1.2	1	1.2	0	0.0	0	0.0	1	1.2	1	1.2	0	0.0	0	0.0
Caseload (%)																
Terminally Ill																
0-5	70	81.4	68	79.1	4	4.7	6	7.0	66	78.6	66	77.6	6	7.1	7	8.2
6-10	4	4.7	4	4.7	0	0.0	0	0.0	4	4.8	4	4.7	0	0.0	0	0.0
11+	8	9.3	8	9.3	0	0.0	0	0.0	8	9.5	8	9.4	0	0.0	0	0.0

Item	Support Voluntary Passive Euthanasia				Against Voluntary Passive Euthanasia				Support Assisted Death				Against Assisted Death			
	Professional		Personal		Professional		Personal		Professional		Personal		Professional		Personal	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Suicidal																
0-10	52	60.5	50	58.1	1	1.2	3	3.5	48	57.1	47	55.3	4	4.8	5	5.9
11-20	13	15.1	13	15.1	1	1.2	1	1.2	13	15.5	13	15.3	1	1.2	1	1.2
21-30	5	5.8	5	5.8	1	1.2	1	1.2	5	6.0	6	7.1	0	0.0	0	0.0
31+	12	14.0	12	14.0	1	1.2	1	1.2	12	14.3	12	14.1	1	1.2	1	1.2
Competence																
Have Training																
Agree	25	29.8	25	29.8	4	4.8	4	4.8	25	30.1	26	31.0	3	3.6	3	3.6
Neither	17	20.2	16	19.0	0	0.0	1	1.2	17	20.5	16	19.0	0	0.0	1	1.2
Disagree	38	45.2	37	44.0	0	0.0	1	1.2	36	43.4	35	41.7	2	2.4	3	3.6
Feel Competent																
Agree	26	31.0	25	29.8	3	3.6	4	4.8	26	31.3	26	31.0	2	2.4	3	3.6
Neither	15	17.9	15	17.9	1	1.2	1	1.2	15	18.1	15	17.9	1	1.2	1	1.2
Disagree	39	46.4	38	45.2	0	0.0	1	1.2	37	44.6	36	42.9	2	2.4	3	3.6

Note: Percentages reflect the amount of people with a demographic characteristic in the particular category (e.g., professional voluntary active euthanasia perceptions). BC = British Columbia; MB = Manitoba; NB = New Brunswick; NL = Newfoundland; PEI = Prince Edward Island.

Table F2

Frequency Distribution of the Willingness to Support a Request for Assisted Death

As a registered psychologist, I would be willing to tell the doctor that I support the client's request to receive assistance in dying.													
Item		Vignette 1						Vignette 2					
		Agree		Disagree		Neither		Agree		Disagree		Neither	
		<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Gender													
	Male	11	13.1	7	8.3	5	6.0	3	3.6	16	19.3	4	4.8
	Female	33	39.3	11	13.1	17	20.2	6	7.2	43	51.8	11	13.3
Age													
	20-29	1	1.2	1	1.2	2	2.4	0	0.0	2	2.4	1	1.2
	30-39	8	9.5	3	3.6	4	4.8	2	2.4	10	12.0	3	3.6
	40-49	10	11.9	4	4.8	5	6.0	2	2.4	12	14.5	5	6.0
	50-59	10	11.9	5	6.0	5	6.0	1	1.2	17	20.5	2	2.4
	60+	15	17.9	5	6.0	6	7.1	4	4.8	18	21.7	4	31.3
Province													
	BC	5	6.0	2	2.4	3	3.6	1	1.2	6	7.3	3	3.7
	MB	11	13.3	4	4.8	6	7.2	1	1.2	17	20.7	3	3.7
	NB	14	16.9	7	8.4	6	7.2	3	3.7	20	24.4	3	3.7
	NL	11	13.3	5	6.0	3	3.6	4	4.9	11	13.4	4	4.9
	PEI	2	2.4	0	0.0	4	4.8	0	0.0	4	4.9	2	2.4
Specialty													
	Clinical	27	32.1	12	14.3	14	16.7	6	7.2	37	44.6	10	12.0
	Counselling	12	14.3	6	7.1	1	1.2	1	1.2	14	16.9	4	4.8
	Forensic	3	3.6	0	0.0	2	2.4	1	1.2	3	3.6	1	1.2
	Child/ Adolescent	8	9.5	2	2.4	5	6.0	3	3.6	10	12.0	2	2.4
	School	9	10.7	3	3.6	4	4.8	1	1.2	14	16.9	1	1.2
	Health	14	16.7	4	4.8	5	6.0	1	1.2	17	20.5	4	4.8

As a registered psychologist, I would be willing to tell the doctor that I support the client's request to receive assistance in dying.												
Item	Vignette 1						Vignette 2					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Organizational	3	3.6	0	0.0	0	0.0	1	1.2	2	2.4	0	0.0
Couples/Family	6	7.1	3	3.6	3	3.6	1	1.2	9	10.8	2	2.4
Research	4	4.8	2	2.4	4	4.8	1	1.2	7	8.5	2	2.4
Professor/Teaching	9	10.7	4	4.8	3	3.6	2	2.4	10	12.0	4	4.8
Supervision	3	3.6	2	2.4	5	6.0	1	1.2	7	8.4	2	2.4
Group	5	6.0	1	1.2	0	0.0	0	0.0	4	4.8	2	2.4
Other	2	2.4	1	1.2	1	1.2	1	1.2	3	3.6	0	0.0
Practice												
Private	18	21.4	8	9.5	7	8.3	4	4.8	22	26.5	7	8.4
Hospital	10	11.9	4	4.8	5	6.0	2	2.4	12	14.5	4	4.8
Non-Profit	2	2.4	0	0.0	0	0.0	0	0.0	1	1.2	1	1.2
Correctional	2	2.4	1	1.2	1	1.2	1	1.2	3	3.6	0	0.0
Academic	7	8.3	4	4.8	4	4.8	1	1.2	12	14.5	2	2.4
School	7	8.3	3	3.6	0	0.0	1	1.2	6	7.2	3	3.6
Other	6	7.1	2	2.4	6	7.1	1	1.2	10	12.0	3	3.6
Practice Length												
0-4	6	7.2	3	3.6	5	6.0	1	1.2	9	11.0	3	3.7
5-9	6	7.2	7	8.4	9	10.8	2	2.4	15	18.3	5	6.1
10-14	8	9.6	4	4.8	2	2.4	1	1.2	10	12.2	3	3.7
15-19	11	13.3	0	0.0	0	0.0	2	2.4	9	11.0	0	0.0
20-24	4	4.8	1	1.2	2	2.4	0	0.0	6	7.3	1	1.2
25-29	4	4.8	0	0.0	3	3.6	1	1.2	4	4.9	2	2.4
30-34	2	2.4	1	1.2	0	0.0	1	1.2	2	2.4	0	0.0
35+	3	3.6	1	1.2	1	1.2	1	1.2	3	3.7	1	1.2

As a registered psychologist, I would be willing to tell the doctor that I support the client's request to receive assistance in dying.												
Item	Vignette 1						Vignette 2					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Religion												
Moral Guide												
Agree	9	17.3	7	13.5	5	9.6	1	2.0	14	27.5	5	9.8
Neither	8	15.4	3	5.8	5	9.6	1	2.0	13	25.5	2	3.9
Disagree	7	13.5	4	7.7	4	7.7	1	2.0	14	27.5	0	0.0
Involvement												
Agree	12	22.6	9	17.0	5	9.4	2	3.8	21	40.4	3	5.8
Neither	0	0.0	2	3.8	3	5.7	0	0.0	3	5.8	1	1.9
Disagree	11	20.8	5	9.4	6	11.3	1	1.9	19	36.5	2	3.8
End-of-Life												
Agree	14	25.9	12	22.2	9	16.7	2	3.8	27	50.9	5	9.4
Neither	8	14.8	3	5.6	4	7.4	0	0.0	13	24.5	2	3.8
Disagree	2	3.7	1	1.9	1	1.9	1	1.9	3	5.7	0	0.0
Supported Someone Terminally Ill												
Professionally												
Yes	18	21.4	8	9.5	10	11.9	3	3.6	26	31.3	6	7.2
No	26	31.0	10	11.9	12	14.3	6	7.2	33	39.8	9	10.8
Personally												
Yes	27	32.5	10	12.0	12	14.5	6	7.3	37	45.1	6	7.3
No	16	19.3	7	8.4	10	12.0	3	3.7	20	24.4	9	11.0
Not Sure	0	0.0	1	1.2	0	0.0	0	0.0	1	1.2	0	0.0

As a registered psychologist, I would be willing to tell the doctor that I support the client's request to receive assistance in dying.												
Item	Vignette 1						Vignette 2					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Caseload (%)												
Terminally Ill												
0-5	34	40.5	17	20.2	21	25.0	8	9.6	50	60.2	13	15.7
6-10	4	4.8	0	0.0	0	0.0	0	0.0	4	4.8	0	0.0
11+	6	7.1	1	1.2	1	1.2	1	1.2	5	6.0	2	2.4
Suicidal												
0-10	27	32.1	13	15.5	11	13.1	5	6.0	40	48.2	6	7.2
11-20	9	10.7	3	3.6	2	2.4	1	1.2	7	8.4	6	7.2
21-30	2	2.4	1	1.2	3	3.6	1	1.2	3	3.6	1	1.2
31+	6	7.1	1	1.2	6	7.1	2	2.4	9	10.8	2	2.4
Competence												
Have Training												
Agree	17	20.2	6	7.1	6	7.1	3	3.6	21	25.3	5	6.0
Neither	9	10.7	3	3.6	5	6.0	1	1.2	12	14.5	4	4.8
Disagree	18	21.4	9	10.7	11	13.1	5	6.0	26	31.3	6	7.2
Feel Competent												
Agree	17	20.2	6	7.1	6	7.1	3	3.6	23	27.7	3	3.6
Neither	10	11.9	1	1.2	5	6.0	1	1.2	8	9.6	7	8.4
Disagree	17	20.2	11	13.1	11	13.1	5	6.0	28	33.7	5	6.0

Note: Percentages reflect the amount of people with a demographic characteristic in the particular category (e.g., vignette 1).

BC = British Columbia; MB = Manitoba; NB = New Brunswick; NL = Newfoundland; PEI = Prince Edward Island.

Table F3

Frequency Distribution of the Ability to Remain Neutral

		As a registered psychologist, I would be able to stay neutral (i.e., not share my opinion) when helping the client identify the benefits and consequences of the decision to end his or her life.											
		Vignette 1						Vignette 2					
		Agree		Disagree		Neither		Agree		Disagree		Neither	
Item		<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Gender													
	Male	16	19.0	4	4.8	3	3.6	11	13.3	7	8.4	5	6.0
	Female	50	59.5	2	2.4	9	10.7	34	41.0	13	15.7	13	15.7
Age													
	20-29	3	3.6	0	0.0	1	1.2	1	1.2	0	0.0	2	2.4
	30-39	13	15.5	0	0.0	2	2.4	10	12.0	1	1.2	4	4.8
	40-49	16	19.0	1	1.2	2	2.4	12	14.5	5	6.0	2	2.4
	50-59	15	17.9	2	2.4	3	3.6	8	9.6	8	9.6	4	4.8
	60+	19	22.6	3	3.6	4	4.8	14	16.9	6	7.2	6	7.2
Province													
	BC	6	7.2	0	0.0	4	4.8	5	6.1	1	1.2	4	4.9
	MB	16	19.3	4	4.8	1	1.2	11	13.4	7	8.5	3	3.7
	NB	22	26.5	1	1.2	4	4.8	16	19.5	4	4.9	6	7.3
	NL	17	20.5	1	1.2	1	1.2	11	13.4	6	7.3	2	2.4
	PEI	5	6.0	0	0.0	1	1.2	2	2.4	2	2.4	2	2.4
Specialty													
	Clinical	39	46.4	4	4.8	10	11.9	28	33.7	13	15.7	12	14.5
	Counselling	15	17.9	1	1.2	3	3.6	12	14.5	4	4.8	3	3.6
	Forensic	4	4.8	0	0.0	1	1.2	3	3.6	1	1.2	1	1.2
	Child/Adolescent	11	13.1	1	1.2	3	3.6	5	6.0	7	8.4	3	3.6
	School	12	14.3	2	2.4	2	2.4	5	6.0	8	9.6	3	3.6
	Health	18	21.4	1	1.2	4	4.8	13	15.7	5	6.0	4	4.8

As a registered psychologist, I would be able to stay neutral (i.e., not share my opinion) when helping the client identify the benefits and consequences of the decision to end his or her life.												
Item	Vignette 1						Vignette 2					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Organizational	3	3.6	0	0.0	0	0.0	1	1.2	2	2.4	0	0.0
Couples/Family	7	8.3	1	1.2	4	4.8	5	6.0	4	4.8	3	3.6
Research	8	9.6	0	0.0	2	2.4	7	8.5	1	1.2	2	2.4
Professor/Teaching	12	14.3	0	0.0	4	4.8	9	10.8	3	3.6	4	4.8
Supervision	9	10.7	0	0.0	1	1.2	7	8.4	3	3.6	0	0.0
Group	5	6.0	0	0.0	1	1.2	3	3.6	3	3.6	0	0.0
Other	3	3.6	1	1.2	0	0.0	2	2.4	1	1.2	1	1.2
Practice												
Private	23	27.4	4	4.8	6	7.1	15	18.1	8	9.6	10	12.0
Hospital	15	17.9	1	1.2	3	3.6	11	13.3	4	4.8	3	3.6
Non-Profit	2	2.4	0	0.0	0	0.0	1	1.2	1	1.2	0	0.0
Correctional	3	3.6	0	0.0	1	1.2	3	3.6	1	1.2	0	0.0
Academic	11	13.1	1	1.2	3	3.6	8	9.6	4	4.8	3	3.6
School	10	11.9	0	0.0	0	0.0	6	7.2	3	3.6	1	1.2
Other	11	13.1	0	0.0	3	3.6	9	10.8	3	3.6	2	2.4
Practice Length												
0-4	11	13.3	0	0.0	3	3.6	7	8.5	2	2.4	4	4.9
5-9	17	20.5	1	1.2	4	4.8	13	15.9	2	2.4	7	8.5
10-14	13	15.7	1	1.2	0	0.0	8	9.8	5	6.1	1	1.2
15-19	8	9.6	1	1.2	2	2.4	5	6.1	4	4.9	2	2.4
20-24	5	6.0	1	1.2	1	1.2	3	3.7	3	3.7	1	1.2
25-29	5	6.0	1	1.2	1	1.2	4	4.9	2	2.4	1	1.2
30-34	2	2.4	0	0.0	1	1.2	1	1.2	0	0.0	2	2.4
35+	4	4.8	1	1.2	0	0.0	3	3.7	2	2.4	0	0.0

As a registered psychologist, I would be able to stay neutral (i.e., not share my opinion) when helping the client identify the benefits and consequences of the decision to end his or her life.												
Item	Vignette 1						Vignette 2					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Religion												
Moral Guide												
Agree	16	30.8	1	1.9	4	7.7	10	19.6	5	9.8	5	9.8
Neither	9	17.3	2	3.8	5	9.6	6	11.8	4	7.8	6	11.8
Disagree	12	23.1	2	3.8	1	1.9	7	13.7	7	13.7	1	2.0
Involvement												
Agree	16	30.2	2	3.8	8	15.1	10	19.2	9	17.3	7	13.5
Neither	5	9.4	0	0.0	0	0.0	3	5.8	0	0.0	1	1.9
Disagree	16	30.2	3	5.7	3	5.7	9	17.3	7	13.5	6	11.5
End-of-Life												
Agree	24	44.4	3	5.6	8	14.8	15	28.3	10	18.9	9	17.0
Neither	12	22.2	1	1.9	2	3.7	6	11.3	4	7.5	5	9.4
Disagree	2	3.7	1	1.9	1	1.9	2	3.8	2	3.8	0	0.0
Supported												
Someone												
Terminally Ill												
Professionally												
Yes	29	34.5	4	4.8	3	3.6	18	21.7	9	10.8	8	9.6
No	37	44.0	2	2.4	9	10.7	27	32.5	11	13.3	10	12.0
Personally												
Yes	37	44.6	4	4.8	8	9.6	26	31.7	12	14.6	11	13.4
No	28	33.7	1	1.2	4	4.8	18	22.0	7	8.5	7	8.5
Not Sure	1	1.2	0	0.0	0	0.0	1	1.2	0	0.0	0	0.0

As a registered psychologist, I would be able to stay neutral (i.e., not share my opinion) when helping the client identify the benefits and consequences of the decision to end his or her life.												
Item	Vignette 1						Vignette 2					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Caseload (%)												
Terminally Ill												
0-5	55	65.5	6	7.1	11	13.1	38	45.8	18	21.7	15	18.1
6-10	4	4.8	0	0.0	0	0.0	3	3.6	1	1.2	0	0.0
11+	7	8.3	0	0.0	1	1.2	4	4.8	1	1.2	3	3.6
Suicidal												
0-10	39	46.4	4	4.8	8	9.5	27	32.5	14	16.9	10	12.0
11-20	9	10.7	2	2.4	3	3.6	7	8.4	5	6.0	2	2.4
21-30	6	7.1	0	0.0	0	0.0	3	3.6	0	0.0	2	2.4
31+	12	14.3	0	0.0	1	1.2	8	9.6	1	1.2	4	4.8
Competence												
Have Training												
Agree	23	27.4	3	3.6	3	3.6	15	18.1	9	10.8	5	6.0
Neither	12	14.3	0	0.0	5	6.0	7	8.4	4	4.8	6	7.2
Disagree	31	36.9	3	3.6	4	4.8	23	27.7	7	8.4	7	8.4
Feel Competent												
Agree	23	27.4	3	3.6	3	3.6	14	16.9	11	13.3	4	4.8
Neither	12	14.3	0	0.0	4	4.8	8	9.6	0	0.0	8	9.6
Disagree	31	36.9	3	3.6	5	6.0	23	27.7	9	10.8	6	7.2

Note: Percentages reflect the amount of people with a demographic characteristic in the particular category (e.g., vignette 1).

BC = British Columbia; MB = Manitoba; NB = New Brunswick; NL = Newfoundland; PEI = Prince Edward Island.

Table F4

Frequency Distribution of Personal Requests for Assisted Death

		If I was the client in this scenario, and had been suffering like he or she has for X years, I would ask for assistance in dying.											
		Vignette 1 (X = 3)						Vignette 2 (X = 30)					
		Agree		Disagree		Neither		Agree		Disagree		Neither	
Item		<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Gender													
	Male	8	9.5	8	9.5	7	8.3	2	2.4	11	13.3	10	12.3
	Female	27	32.1	6	7.1	28	33.3	12	14.5	20	24.1	28	33.7
Age													
	20-29	1	1.2	0	0.0	3	3.6	0	0.0	1	1.2	2	2.4
	30-39	5	6.0	0	0.0	10	11.9	5	6.0	2	2.4	8	9.6
	40-49	7	8.3	4	4.8	8	9.5	0	0.0	11	13.3	8	9.6
	50-59	6	7.1	6	7.1	8	9.5	1	1.2	7	8.4	12	14.5
	60+	16	19.0	4	4.8	6	7.1	8	9.6	10	12.0	8	9.6
Province													
	BC	7	8.4	1	1.2	2	2.4	1	1.2	5	6.1	4	4.9
	MB	7	8.4	4	4.8	10	12.0	4	4.9	9	11.0	8	9.8
	NB	9	10.8	4	4.8	14	16.9	5	6.1	6	7.3	15	18.3
	NL	9	10.8	4	4.8	6	7.2	4	4.9	7	8.5	8	9.8
	PEI	3	3.6	1	1.2	2	2.4	0	0.0	4	4.9	2	2.4
Specialty													
	Clinical	19	22.6	7	8.3	27	32.1	10	12.0	16	19.3	27	32.5
	Counselling	11	13.1	4	4.8	4	4.8	4	4.8	9	10.8	6	7.2
	Forensic	3	3.6	0	0.0	2	2.4	0	0.0	1	1.2	4	4.8
	Child/ Adolescent	7	8.3	3	3.6	5	6.0	2	2.4	7	8.4	6	7.2
	School	7	8.3	3	3.6	6	7.1	1	1.2	11	13.3	4	4.8
	Health	7	8.3	4	4.8	12	14.3	3	3.6	7	8.4	12	14.5

If I was the client in this scenario, and had been suffering like he or she has for X years, I would ask for assistance in dying.												
Item	Vignette 1 (X = 3)						Vignette 2 (X = 30)					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Organizational	2	2.4	1	1.2	0	0.0	0	0.0	1	1.2	2	2.4
Couples/Family	5	6.0	2	2.4	5	6.0	4	4.8	4	4.8	4	4.8
Research	4	4.8	3	3.6	3	3.6	1	1.2	6	7.3	3	3.7
Professor/Teaching	9	10.7	3	3.6	4	4.8	1	1.2	9	10.8	6	7.2
Supervision	4	4.8	1	1.2	5	6.0	1	1.2	5	6.0	4	4.8
Group	3	3.6	1	1.2	2	2.4	0	0.0	3	3.6	3	3.6
Other	2	2.4	1	1.2	1	1.2	2	2.4	1	1.2	1	1.2
Practice												
Private	15	17.9	5	6.0	13	15.5	7	8.4	11	13.3	15	18.1
Hospital	5	6.0	3	3.6	11	13.1	4	4.8	5	6.0	9	10.8
Non-Profit	1	1.2	0	0.0	1	1.2	0	0.0	0	0.0	2	2.4
Correctional	2	2.4	0	0.0	2	2.4	0	0.0	2	2.4	2	2.4
Academic	8	9.5	3	3.6	4	4.8	2	2.4	7	8.4	6	7.2
School	5	6.0	3	3.6	2	2.4	1	1.2	5	6.0	4	4.8
Other	6	7.1	1	1.2	7	8.3	2	2.4	6	7.2	6	7.2
Practice Length												
0-4	4	4.8	2	2.4	8	9.6	3	3.7	4	4.9	6	7.3
5-9	7	8.4	3	3.6	12	14.5	4	4.9	7	8.5	11	13.4
10-14	4	4.8	5	6.0	5	6.0	1	1.2	5	6.1	8	9.8
15-19	9	10.8	0	0.0	2	2.4	0	0.0	6	7.3	5	6.1
20-24	3	3.6	1	1.2	3	3.6	1	1.2	4	4.9	2	2.4
25-29	3	3.6	0	0.0	4	4.8	2	2.4	0	0.0	5	6.1
30-34	2	2.4	1	1.2	0	0.0	1	1.2	1	1.2	1	1.2
35+	3	3.6	1	1.2	1	1.2	2	2.4	3	3.7	0	0.0

If I was the client in this scenario, and had been suffering like he or she has for X years, I would ask for assistance in dying.												
Item	Vignette 1 (X = 3)						Vignette 2 (X = 30)					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Religion												
Moral Guide												
Agree	8	15.4	6	11.5	7	13.5	2	3.9	11	21.6	7	13.7
Neither	5	9.6	1	1.9	10	19.2	3	5.9	8	15.7	5	9.8
Disagree	5	9.6	4	7.7	6	11.5	3	5.9	4	7.8	8	15.7
Involvement												
Agree	7	13.2	8	15.1	11	20.8	4	7.7	14	26.9	8	15.4
Neither	1	1.9	0	0.0	4	7.5	1	1.9	0	0.0	3	5.8
Disagree	9	17.0	3	5.7	10	18.9	3	5.8	9	17.3	10	19.2
End-of-Life												
Agree	10	18.5	8	14.8	17	31.5	6	11.3	16	30.2	12	22.6
Neither	8	14.8	2	3.7	5	9.3	1	1.9	6	11.3	8	15.1
Disagree	0	0.0	1	1.9	3	5.6	1	1.9	1	1.9	2	3.8
Supported Someone Terminally Ill												
Professionally												
Yes	13	15.5	7	8.3	16	19.0	6	7.2	12	14.5	17	20.5
No	22	26.2	7	8.3	19	22.6	8	9.6	19	22.9	21	25.3
Personally												
Yes	21	25.3	8	9.6	20	24.1	8	9.8	17	20.7	24	29.3
No	14	16.9	6	7.2	13	15.7	5	6.1	13	15.9	14	17.1
Not Sure	0	0.0	0	0.0	1	1.2	1	1.2	0	0.0	0	0.0

If I was the client in this scenario, and had been suffering like he or she has for X years, I would ask for assistance in dying.													
Item	Vignette 1 (X = 3)						Vignette 2 (X = 30)						
	Agree		Disagree		Neither		Agree		Disagree		Neither		
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	
Caseload (%)													
Terminally Ill													
0-5	28	33.3	13	15.5	31	36.9	12	14.5	28	33.7	31	37.3	
6-10	3	3.6	0	0.0	1	1.2	0	0.0	3	3.6	1	1.2	
11+	4	4.8	1	1.2	3	3.6	2	2.4	0	0.0	6	7.2	
Suicidal													
0-10	19	22.6	11	13.1	21	25.0	8	9.6	23	27.7	20	24.1	
11-20	7	8.3	2	2.4	5	6.0	3	3.6	4	4.8	7	8.4	
21-30	3	3.6	0	0.0	3	3.6	1	1.2	1	1.2	3	3.6	
31+	6	7.1	1	1.2	6	7.1	2	2.4	3	3.6	8	9.6	
Competence													
Have Training													
Agree	15	17.9	6	7.1	8	9.5	5	6.0	13	15.7	11	13.3	
Neither	6	7.1	2	2.4	9	10.7	2	2.4	4	4.8	11	13.3	
Disagree	14	16.7	6	7.1	18	21.4	7	8.4	14	16.9	16	19.3	
Feel Competent													
Agree	15	17.9	6	7.1	8	9.5	5	6.0	12	14.5	12	14.5	
Neither	7	8.3	1	1.2	8	9.5	3	3.6	4	4.8	9	10.8	
Disagree	13	15.5	7	8.3	19	22.6	6	7.2	15	18.1	17	20.5	

Note: Percentages reflect the amount of people with a demographic characteristic in the particular category (e.g., vignette 1).

BC = British Columbia; MB = Manitoba; NB = New Brunswick; NL = Newfoundland; PEI = Prince Edward Island.

Table F5

Frequency Distribution of Perceptions According to Age

		I would be willing, as a registered psychologist, to support my client's request to die by talking to the doctor even if he or she was 30 years old, instead of X years old.											
		Vignette 1 (X = 80)						Vignette 2 (X = 65)					
		Agree		Disagree		Neither		Agree		Disagree		Neither	
Item		<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Gender													
	Male	9	10.7	9	10.7	5	6.0	1	1.2	18	21.7	4	4.8
	Female	30	35.7	12	14.3	19	22.6	1	1.2	47	56.6	12	14.5
Age													
	20-29	2	2.4	1	1.2	1	1.2	0	0.0	3	3.6	0	0.0
	30-39	7	8.3	3	3.6	5	6.0	0	0.0	11	13.3	4	4.8
	40-49	9	10.7	5	6.0	5	6.0	0	0.0	14	16.9	5	6.0
	50-59	9	10.7	7	8.3	4	4.8	1	1.2	17	20.5	2	2.4
	60+	12	14.3	5	6.0	9	10.7	1	1.2	20	24.1	5	6.0
Province													
	BC	3	3.6	2	2.4	5	6.0	0	0.0	9	11.0	1	1.2
	MB	10	12.0	6	7.2	5	6.0	1	1.2	17	20.7	3	3.7
	NB	14	16.9	6	7.2	7	8.4	1	1.2	20	24.4	5	6.1
	NL	10	12.0	5	6.0	4	4.8	0	0.0	13	15.9	6	7.3
	PEI	1	1.2	2	2.4	3	3.6	0	0.0	5	6.1	1	1.2
Specialty													
	Clinical	25	29.8	12	14.3	16	19.0	1	1.2	41	49.4	11	13.3
	Counselling	10	11.9	5	6.0	4	4.8	0	0.0	15	18.1	4	4.8
	Forensic	3	3.6	0	0.0	2	2.4	0	0.0	4	4.8	1	1.2
	Child/ Adolescent	5	6.0	7	8.3	3	3.6	0	0.0	12	14.5	3	3.6
	School	8	9.5	5	6.0	3	3.6	1	1.2	13	15.7	2	2.4
	Health	11	13.1	5	6.0	7	8.3	0	0.0	18	21.7	4	4.8

I would be willing, as a registered psychologist, to support my client's request to die by talking to the doctor even if he or she was 30 years old, instead of X years old.												
Item	Vignette 1 (X = 80)						Vignette 2 (X = 65)					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Organizational	1	1.2	1	1.2	1	1.2	0	0.0	3	3.6	0	0.0
Couples/Family	4	4.8	3	3.6	5	6.0	1	1.2	10	12.0	1	1.2
Research	3	3.6	3	3.6	4	4.8	0	0.0	8	9.8	2	2.4
Professor/Teaching	8	9.5	4	4.8	4	4.8	1	1.2	10	12.0	5	6.0
Supervision	3	3.6	3	3.6	4	4.8	0	0.0	7	8.4	3	3.6
Group	3	3.6	2	2.4	1	1.2	0	0.0	5	6.0	1	1.2
Other	3	3.6	1	1.2	0	0.0	0	0.0	4	4.8	0	0.0
Practice												
Private	16	19.0	9	10.7	8	9.5	1	1.2	27	32.5	5	6.0
Hospital	8	9.5	6	7.1	5	6.0	0	0.0	13	15.7	5	6.0
Non-Profit	1	1.2	0	0.0	1	1.2	0	0.0	1	1.2	1	1.2
Correctional	2	2.4	1	1.2	1	1.2	0	0.0	3	3.6	1	1.2
Academic	6	7.1	4	4.8	5	6.0	1	1.2	12	14.5	2	2.4
School	5	6.0	3	3.6	2	2.4	0	0.0	7	8.4	3	3.6
Other	6	7.1	2	2.4	6	7.1	0	0.0	12	14.5	2	2.4
Practice Length												
0-4	6	7.2	4	4.8	4	4.8	0	0.0	10	12.2	3	3.7
5-9	8	9.6	6	7.2	8	9.6	0	0.0	16	19.5	6	7.3
10-14	5	6.0	6	7.2	3	3.6	1	1.2	10	12.2	3	3.7
15-19	10	12.0	0	0.0	1	1.2	0	0.0	10	12.2	1	1.2
20-24	2	2.4	1	1.2	4	4.8	0	0.0	5	6.1	2	2.4
25-29	4	4.8	1	1.2	2	2.4	1	1.2	5	6.1	1	1.2
30-34	1	1.2	1	1.2	1	1.2	0	0.0	3	3.7	0	0.0
35+	3	3.6	1	1.2	1	1.2	0	0.0	5	6.1	0	0.0

I would be willing, as a registered psychologist, to support my client's request to die by talking to the doctor even if he or she was 30 years old, instead of X years old.												
Item	Vignette 1 (X = 80)						Vignette 2 (X = 65)					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Religion												
Moral Guide												
Agree	5	9.6	8	15.4	8	15.4	0	0.0	16	31.4	4	7.8
Neither	8	15.4	2	3.8	6	11.5	0	0.0	14	27.5	2	3.9
Disagree	5	9.6	6	11.5	4	7.7	0	0.0	14	27.5	1	2.0
Involvement												
Agree	8	15.1	10	18.9	8	15.1	0	0.0	23	44.2	3	5.8
Neither	0	0.0	1	1.9	4	7.5	0	0.0	3	5.8	1	1.9
Disagree	10	18.9	6	11.3	6	11.3	0	0.0	19	36.5	3	5.8
End-of-Life												
Agree	11	20.4	12	22.2	12	22.2	0	0.0	28	52.8	6	11.3
Neither	5	9.3	4	7.4	6	11.1	0	0.0	14	26.4	1	1.9
Disagree	2	3.7	1	1.9	1	1.9	0	0.0	3	5.7	1	1.9
Supported												
Someone												
Terminally Ill												
Professionally												
Yes	16	19.0	10	11.9	10	11.9	1	1.2	28	33.7	6	7.2
No	23	27.4	11	13.1	14	16.7	1	1.2	37	44.6	10	12.0
Personally												
Yes	24	28.9	12	14.5	13	15.7	2	2.4	42	51.2	5	6.1
No	14	16.9	9	10.8	10	12.0	0	0.0	22	26.8	10	12.2
Not Sure	0	0.0	0	0.0	1	1.2	0	0.0	1	1.2	0	0.0

I would be willing, as a registered psychologist, to support my client's request to die by talking to the doctor even if he or she was 30 years old, instead of X years old.												
Item	Vignette 1 (X = 80)						Vignette 2 (X = 65)					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Caseload (%)												
Terminally Ill												
0-5	29	34.5	20	23.8	23	27.4	2	2.4	56	67.5	13	15.7
6-10	4	4.8	0	0.0	0	0.0	0	0.0	4	4.8	0	0.0
11+	6	7.1	1	1.2	1	1.2	0	0.0	5	6.0	3	3.6
Suicidal												
0-10	24	28.6	15	17.9	12	14.3	1	1.2	42	50.6	8	9.6
11-20	6	7.1	3	3.6	5	6.0	0	0.0	11	13.3	3	3.6
21-30	2	2.4	1	1.2	3	3.6	1	1.2	3	3.6	1	1.2
31+	7	8.3	2	2.4	4	4.8	0	0.0	9	10.8	4	4.8
Competence												
Have Training												
Agree	15	17.9	9	10.7	5	6.0	2	2.4	24	28.9	3	3.6
Neither	7	8.3	3	3.6	7	8.3	0	0.0	14	16.9	3	3.6
Disagree	17	20.2	9	10.7	12	14.3	0	0.0	27	32.5	10	12.0
Feel Competent												
Agree	16	19.0	8	9.5	5	6.0	2	2.4	24	28.9	3	3.6
Neither	7	8.3	2	2.4	7	8.3	0	0.0	12	14.5	4	4.8
Disagree	16	19.0	11	13.1	12	14.3	0	0.0	29	34.9	9	10.8

Note: Percentages reflect the amount of people with a demographic characteristic in the particular category (e.g., vignette 1).

BC = British Columbia; MB = Manitoba; NB = New Brunswick; NL = Newfoundland; PEI = Prince Edward Island.

Table F6

Frequency Distribution of Improvement Perceptions

I would be willing, as a registered psychologist, to support my client's request to die by talking to the doctor even if there was a chance of meaningful improvement													
Item		Vignette 1						Vignette 2					
		Agree		Disagree		Neither		Agree		Disagree		Neither	
		<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Gender													
	Male	3	3.6	16	19.0	4	4.8	1	1.2	21	25.3	1	1.2
	Female	2	2.4	41	48.8	18	21.4	1	1.2	53	63.9	6	7.2
Age													
	20-29	0	0.0	2	2.4	2	2.4	0	0.0	3	3.6	0	0.0
	30-39	0	0.0	10	11.9	5	6.0	0	0.0	13	15.7	2	2.4
	40-49	0	0.0	14	16.7	5	6.0	0	0.0	18	21.7	1	1.2
	50-59	2	2.4	16	19.0	2	2.4	1	1.2	19	22.9	0	0.0
	60+	3	3.6	15	17.9	8	9.5	1	1.2	21	25.3	4	4.8
Province													
	BC	0	0.0	7	8.4	3	3.6	0	0.0	9	11.0	1	1.2
	MB	2	2.4	16	19.3	3	3.6	0	0.0	20	24.4	1	1.2
	NB	2	2.4	17	20.5	8	9.6	2	2.4	23	28.0	1	1.2
	NL	0	0.0	14	16.9	5	6.0	0	0.0	16	19.5	3	3.7
	PEI	1	1.2	2	2.4	3	3.6	0	0.0	5	6.1	1	1.2
Specialty													
	Clinical	3	3.6	37	44.0	13	15.5	0	0.0	49	59.0	4	4.8
	Counselling	2	2.4	13	15.5	4	4.8	1	1.2	16	19.3	2	2.4
	Forensic	0	0.0	3	3.6	2	2.4	0	0.0	4	4.8	1	1.2
	Child/ Adolescent	1	1.2	8	9.5	6	7.1	0	0.0	12	14.5	3	3.6
	School	2	2.4	10	11.9	4	4.8	0	0.0	15	18.1	1	1.2
	Health	2	2.4	14	16.7	7	8.3	1	1.2	19	22.9	2	2.4

I would be willing, as a registered psychologist, to support my client's request to die by talking to the doctor even if there was a chance of meaningful improvement												
Item	Vignette 1						Vignette 2					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Organizational	1	1.2	2	2.4	0	0.0	0	0.0	3	3.6	0	0.0
Couples/Family	2	2.4	8	9.5	2	2.4	0	0.0	10	12.0	2	2.4
Research	0	0.0	6	7.2	4	4.8	0	0.0	9	11.0	1	1.2
Professor/Teaching	2	2.4	9	10.7	5	6.0	1	1.2	12	14.5	3	3.6
Supervision	0	0.0	7	8.3	3	3.6	0	0.0	9	10.8	1	1.2
Group	1	1.2	3	3.6	2	2.4	0	0.0	5	6.0	1	1.2
Other	0	0.0	2	2.4	2	2.4	0	0.0	3	3.6	1	1.2
Practice												
Private	3	3.6	24	28.6	6	7.1	1	1.2	29	34.9	3	3.6
Hospital	1	1.2	12	14.3	6	7.1	1	1.2	15	18.1	2	2.4
Non-Profit	0	0.0	1	1.2	1	1.2	0	0.0	1	1.2	1	1.2
Correctional	0	0.0	2	2.4	2	2.4	0	0.0	3	3.6	1	1.2
Academic	2	2.4	9	10.7	4	4.8	1	1.2	13	15.7	1	1.2
School	0	0.0	7	8.3	3	3.6	0	0.0	8	9.6	2	2.4
Other	0	0.0	11	13.1	3	3.6	0	0.0	14	16.9	0	0.0
Practice Length												
0-4	0	0.0	9	10.8	5	6.0	0	0.0	12	14.6	1	1.2
5-9	1	1.2	14	16.9	7	8.4	1	1.2	18	22.0	3	3.7
10-14	1	1.2	12	14.5	1	1.2	1	1.2	13	15.9	0	0.0
15-19	1	1.2	7	8.4	3	3.6	0	0.0	11	13.4	0	0.0
20-24	0	0.0	5	6.0	2	2.4	0	0.0	6	7.3	1	1.2
25-29	1	1.2	5	6.0	1	1.2	0	0.0	6	7.3	1	1.2
30-34	0	0.0	1	1.2	2	2.4	0	0.0	2	2.4	1	1.2
35+	1	1.2	3	3.6	1	1.2	0	0.0	5	6.1	0	0.0

I would be willing, as a registered psychologist, to support my client's request to die by talking to the doctor even if there was a chance of meaningful improvement												
Item	Vignette 1						Vignette 2					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Religion												
Moral Guide												
Agree	1	1.9	15	28.8	5	9.6	0	0.0	19	37.3	1	2.0
Neither	1	1.9	10	19.2	5	9.6	1	2.0	15	29.4	0	0.0
Disagree	0	0.0	11	21.2	4	7.7	0	0.0	13	25.5	2	3.9
Involvement												
Agree	2	3.8	18	34.0	6	11.3	1	1.9	24	46.2	1	1.9
Neither	0	0.0	4	7.5	1	1.9	0	0.0	4	7.7	0	0.0
Disagree	0	0.0	15	28.3	7	13.2	0	0.0	20	38.5	2	3.8
End-of-Life												
Agree	2	3.7	26	48.1	7	13.0	1	1.9	32	60.4	1	1.9
Neither	0	0.0	9	16.7	6	11.1	0	0.0	13	24.5	2	3.8
Disagree	0	0.0	2	3.7	2	3.7	0	0.0	3	5.7	1	1.9
Supported												
Someone												
Terminally Ill												
Professionally												
Yes	4	4.8	24	28.6	8	9.5	1	1.2	31	37.3	3	3.6
No	1	1.2	33	39.3	14	16.7	1	1.2	43	51.8	4	4.8
Personally												
Yes	5	6.0	33	39.8	11	13.3	2	2.4	42	51.2	5	6.1
No	0	0.0	22	26.5	11	13.3	0	0.0	30	36.6	2	2.4
Not Sure	0	0.0	1	1.2	0	0.0	0	0.0	1	1.2	0	0.0

I would be willing, as a registered psychologist, to support my client's request to die by talking to the doctor even if there was a chance of meaningful improvement												
Item	Vignette 1						Vignette 2					
	Agree		Disagree		Neither		Agree		Disagree		Neither	
	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%	<i>f</i>	%
Caseload (%)												
Terminally Ill												
0-5	3	3.6	50	59.5	19	22.6	1	1.2	65	78.3	5	6.0
6-10	1	1.2	3	3.6	0	0.0	0	0.0	4	4.8	0	0.0
11+	1	1.2	4	4.8	3	3.6	1	1.2	5	6.0	2	2.4
Suicidal												
0-10	2	2.4	33	39.3	16	19.0	2	2.4	44	53.0	5	6.0
11-20	2	2.4	11	13.1	1	1.2	0	0.0	14	16.9	0	0.0
21-30	1	1.2	4	4.8	1	1.2	0	0.0	4	4.8	1	1.2
31+	0	0.0	9	10.7	4	4.8	0	0.0	12	14.5	1	1.2
Competence												
Have Training												
Agree	4	4.8	20	23.8	5	6.0	1	1.2	27	32.5	1	1.2
Neither	0	0.0	13	15.5	4	4.8	0	0.0	16	19.3	1	1.2
Disagree	1	1.2	24	28.6	13	15.5	1	1.2	31	37.3	5	6.0
Feel Competent												
Agree	4	4.8	20	23.8	5	6.0	1	1.2	27	32.5	1	1.2
Neither	0	0.0	12	14.3	4	4.8	0	0.0	15	18.1	1	1.2
Disagree	1	1.2	25	29.8	13	15.5	1	1.2	32	38.6	5	6.0

Note: Percentages reflect the amount of people with a demographic characteristic in the particular category (e.g., vignette 1).

BC = British Columbia; MB = Manitoba; NB = New Brunswick; NL = Newfoundland; PEI = Prince Edward Island.

Appendix G: Kendall's Tau-b Rank Correlation for Practice Location

Table G1

Perceptions of Assisted Death

Practice Location		Right to Refuse Treatment (Professional)	Right to Refuse Treatment (Personal)	Right to Receive Assistance (Professional)	Right to Receive Assistance (Personal)
Private Practice	τ	0.09	0.12	0.09	0.05
	p	0.041	0.260	0.390	0.643
	n	86	86	84	85
Hospital	τ	0.02	-0.08	0.14	0.11
	p	0.835	0.462	0.202	0.304
	n	86	86	84	85
Non-Profit	τ	-0.08	-0.08	-0.14	-0.13
	p	0.436	0.467	0.187	0.234
	n	86	86	84	85
Correctional	τ	0.00	0.01	-0.10	-0.08
	p	0.978	0.908	0.333	0.435
	n	86	86	84	85
Academic	τ	-0.16	-0.15	-0.15	-0.11
	p	0.126	0.167	0.172	0.305
	n	86	86	84	85

Practice Location		Right to Refuse Treatment (Professional)	Right to Refuse Treatment (Personal)	Right to Receive Assistance (Professional)	Right to Receive Assistance (Personal)
Primary or Secondary School	τ	-0.05	0.06	-0.14	-0.07
	p	0.623	0.584	0.197	0.484
	n	86	86	84	85
Other	τ	0.06	0.02	-0.07	-0.05
	p	0.589	0.843	0.534	0.598
	n	86	86	84	85

Note. *denotes statistically significant correlation ($p < 0.05$).

Table G2

Assisted Death Perceptions in Vignette 1 (Terminal Illness)

Practice Location		Willing to Support Client Request	Able to Remain Neutral	Would Request Euthanasia Themselves	Would Support if Client was 30 Years Old	Would Support if Chance of Meaningful Improvement
Private Practice	τ	0.05	0.00	0.10	-0.06	0.03
	p	0.643	0.931	0.327	0.544	0.767
	n	85	84	84	84	84

Practice Location		Willing to Support Client Request	Able to Remain Neutral	Would Request Euthanasia Themselves	Would Support if Client was 30 Years Old	Would Support if Chance of Meaningful Improvement
Hospital	τ	0.00	0.04	0.06	0.05	-0.01
	p	0.931	0.689	0.555	0.600	0.905
	n	84	84	84	84	84
Non-Profit	τ	-0.09	-0.01	-0.02	-0.03	0.02
	p	0.356	0.896	0.829	0.771	0.851
	n	84	84	84	84	84
Correctional	τ	0.001	-0.105	-0.031	-0.02	-0.038
	p	0.991	0.31	0.757	0.844	0.712
	n	84	84	84	84	84
Academic	τ	0.05	0.01	-0.03	0.06	-0.05
	p	0.599	0.92	0.764	0.563	0.65
	n	84	84	84	84	84
Primary or Secondary School	τ	-0.02	-0.03	0.04	0.01	0.00
	p	0.845	0.751	0.722	0.891	0.929
	n	84	84	84	84	84
Other	τ	0.05	-0.04	-0.04	-0.02	0.06
	p	0.654	0.669	0.659	0.812	0.557
	n	84	84	84	84	84

Note. *denotes statistically significant correlation ($p < 0.05$).

Table G3

Assisted Death Perceptions in Vignette 2 (Mental Illness)

Practice Location		Willing to Support Client Request	Able to Remain Neutral	Would Request Euthanasia Themselves	Would Support if Client was 30 Years Old	Would Support if Chance of Meaningful Improvement
Private Practice	τ	0.03	-0.07	-0.04	0.06	-0.06
	p	0.807	0.484	0.729	0.550	0.601
	n	83	83	83	83	83
Hospital	τ	-0.07	-0.07	-0.09	-0.08	-0.04
	p	0.518	0.484	0.366	0.470	0.679
	n	83	83	83	83	83
Non-Profit	τ	-0.07	0.04	-0.06	-0.01	-0.05
	p	0.474	0.692	0.591	0.961	0.658
	n	83	83	83	83	83
Correctional	τ	0.00	-0.02	0.09	0.06	0.08
	p	0.991	0.83	0.372	0.547	0.46
	n	83	83	83	83	83
Academic	τ	0.08	0.01	0.09	0.00	-0.06
	p	0.465	0.890	0.365	0.969	0.575
	n	83	83	83	83	83

Primary or Secondary School	τ	-0.10	0.00	0.05	-0.13	-0.07
	p	0.315	0.976	0.603	0.226	0.537
	n	83	83	83	83	83
Other	τ	0.08	-0.08	0.06	0.23*	0.19
	p	0.426	0.448	0.565	0.027	0.081
	n	83	83	83	83	83

Note. *denotes statistically significant correlation ($p < 0.05$).

Appendix H: Spearman's Rho Correlation of Years of Practice

Table H1

Perceptions of Assisted Death

		Right to Refuse Treatment (Professional)	Right to Refuse Treatment (Personal)	Right to Receive Assistance (Professional)	Right to Receive Assistance (Personal)
Years of Practice	r_s	-0.04	-0.20	-0.123	-0.61
	p	0.750	0.858	0.267	0.581
	n	85	85	83	84

Note. *denotes statistically significant correlation ($p < 0.05$).

Table H2

Assisted Death Perceptions in Vignette 1 (Terminal Illness)

		Willing to Support Client Request	Able to Remain Neutral	Would Request Euthanasia Themselves	Would Support if Client was 30 Years Old	Would Support if Chance of Meaningful Improvement
Years of Practice	r_s	-0.29*	0.14	-0.15	-0.13	-0.09
	p	0.009	0.208	0.153	0.251	0.435
	n	83	83	83	83	83

Note. *denotes statistically significant correlation ($p < 0.05$).

Table H3

Assisted Death Perceptions in Vignette 2 (Mental Illness)

Practice Location		Willing to Support Client Request	Able to Remain Neutral	Would Request Euthanasia Themselves	Would Support if Client was 30 Years Old	Would Support if Chance of Meaningful Improvement
Years of Practice	r_s	0.06	0.15	0.04	0.00	-0.14
	p	0.896	0.183	0.699	0.994	0.199
	n	82	82	82	82	82

Note. *denotes statistically significant correlation ($p < 0.05$).