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# HEALTH LOCUS OF CONTROL AND PREFERENCE FOR RIGHT TO DIE LEGISLATION

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#### **Objectives**

To determine whether health locus of control explains support for physician and patient assisted killing under specific circumstances.

#### Subjects

35 males and 89 females undergraduates from a large public university.

#### Questionnaire

All respondents completed a questionnaire that included Form B of the Multidimensional Health Locus of Control Scale. In addition, they completed six items asking about support hastening death for hopelessly ill patients.

#### Results

For four of six situations, Internal locus of control was significantly associated with support for physicians to assist in or allow hastened death.

### Conclusions

An internal health locus of control may help explain support for right to die legislation.

Right to die debates have attracted significant public attention. Currently no U.S. state allows a physician to hasten death for patients who are terminally ill. However, public-opinion surveys consistently show that the majority of Americans support physician-assisted suicide in cases in which the patient's condition is terminal and there is significant suffering (Hemlock Society, 1990, 1991). There is also growing support for physician aid-in-dying within the medical profession (Wanzer *et al.*, 1989; Cassel and Meier, 1990; Quill, 1991; Brody, 1992). Such merciful killing is already allowed in the Netherlands, although it is technically not legal (de Wachter 1989; van der Maas *et al.*, 1991).

In the United States (U.S.), Washington State, California and Oregon, voters have considered propositions that would have allowed physician-assisted suicide. The Washington and California propositions were narrowly defeated as voters were nearly equally split between those supporting and those opposing physician assisted suicide. Support for the proposition was not clearly predicted from known demographic variables. More recently, voters in the US state of Oregon passed an initiative allowing physicians to hasten death in well defined circumstances. The vote was very close (52% in favor, 48% opposed). This November 1994 action made Oregon unique in its legalization of physician assisted death. However, the initiative is under review by the courts and it has not been implemented. It is expected that similar proposals will be considered in several other U.S. states (Quill *et al.*, 1992).

This paper considers whether social learning variables may provide an explanation for these differences. Specifically, we consider health locus of control as an explanatory variable. A variety of studies has suggested that health locus of control is an important factor in health behavior (Wallston, 1993). A belief in internal control describes the expectation that rewards and punishment in life are under direct personal control. For example, a person who believes in internal control thinks that getting a promotion, achieving in school, or avoiding an illness result from something that they have done. The belief in external control suggests that positive or negative outcomes are the result of luck or chance. Studies of locus of control relevant to health have identified a third dimension, known as powerful others, which suggest that beliefs about health outcome are determined by other people such as health care providers (Wallston, Wallston and DeVellis, 1978). In this report we explore the role of health locus of control in relation to support for right to death legislation.

## METHOD

## Subjects

The subjects in the study were 35 male and 89 female undergraduate students from a large public university. The participants ranged in age from 19 to 56 years (mean = 24.86, sd = 5.8 years).

# Questionnaire

All respondents completed a questionnaire that included Form B of the Multidimensional Health Locus of Control Scale. The multidimensional health locus of control scale (MHLC) was developed by Wallston, (Wallston and DeVellis (1978) to measure situation specific health-related locus of control. There are two alternative forms of the scale (A and B). Each alternative has 18 items. These items form three uncorrelated (or slightly correlated) scales corresponding to three different locuses of control: *Internal* locus of control representing the belief that a person has individual control over health outcomes, *chance* locus of control indicating that health outcomes are determined largely by chance, and *powerful other* locus of control suggesting that health outcomes are determined by health professionals. Each of the three six-item subscales has six response alternatives. The maximum score for any subscale is 36. Wallston (1989) suggests that scores 31 or higher for internal are considered to be very high.

In addition, the respondents were asked if they agreed or disagreed with three statements. One asked if the doctor should be allowed to withhold life saving treatments such as cardiopulmonary resuscitation if the patient requests it. The second question asked whether a doctor should be allowed to give a patient enough pain pills

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to kill him or her if the patient chooses. The third question asked if the doctor should be allowed to inject large enough doses of pain medication to kill the patient if the patient requests it. Respondents were also asked if they should be allowed to refuse CPR, lethal overdoses of pain pills, or receive lethal injections if they had a terminal illness. The introduction to the questionnaire explained that California was one of several states debating whether doctors and patients should be allowed to hasten death under certain conditions. They were told to assume that a patient had a serious incurable disease that involved much suffering and that pain medicine could not alleviate these problems. They were asked to express their opinions against this background.

# RESULTS

Table 1 summarizes the percentage of respondents endorsing each of the six items. Overall, respondents favoured allowing death to be hastened, either for others or for themselves, in the six situations.

Table 2 breaks down internal locus of control by responses to the six items. The subjects who agreed with the statement that a doctor should be allowed to withhold CPR if the patient requests it had significantly higher internal locus of control scores than subjects who disagreed with the statement ( $F_{1/122} = 6.79$ , p < .01). Similar results were obtained from the respondents personal preferences for CPR if they had a terminal illness. Those who agreed that a doctor should be allowed to withhold CPR also had significantly lower chance scores in comparison to those who felt that doctors should not be allowed to withhold CPR ( $F_{1/119} = 4.19$ , p < .05). There was a significant effect suggesting that internality scores were higher for subjects agreeing with the statement that a doctor should be allowed to give patients enough pain pills to kill if the patients request them ( $F_{1/120} = 3.94$ , p < .05). Further, those who indicated that they would want to be allowed to take a lethal overdose of pain pills had higher internality scores for the items about allowing a doctor to inject fatal doses of pain medication were not

Item	Valid responses	Percent agree/yes	
The doctor should be allowed to withhold life-saving treatments such as CPR if the patient requests it.	124	0.77	
The doctor should be allowed to give the patient enough pain pills, if the patient requests them, to enable the patient to kill himself/herself whenever he/she chooses.	126	0.52	
The doctor should be allowed to inject large enough doses of pain medicine to kill the patient if the patient requests it.	of 124	0.56	
If you had a terminal illness would you personally want to be allowed to refuse CPR?	122 ,	0.79	
If you had a terminal illness would you personally want to be allowed to take a lethal overdose of pain pills?	121	0.60	
If you had a terminal illness would you personally want to be allowed to receive a lethal injection?	122	0.61	

Table 1 Percent agreement by item

Item		Favor		Oppose	
	Mean	SD	Mean	SD	р
The doctor should be allowed to withhold life-saving treatments such as CPR if the patient requests it.	28.71	3.78	26.36	5.42	01
The doctor should be allowed to give the patient enough pain pills, if the patient requests them, to enable the patient to kill himself/herself whenever he/she chooses.	28.74	4.02	27.17	4.59	.03
The doctor should be allowed to inject large enough doses of pain medicine to kill the patient if the patient requests it.	28.63	4.04	27.80	4.56	.14
If you had a terminal illness would you personally want to be allowed to refuse CPR?	28.50	3.93	26.77	5.29	.03
If you had a terminal illness would you personally want to be allowed to take a lethal overdose of pain pills?	28.74	4.02	27.34	4.51	.04
If you had a terminal illness would you personally want to be allowed to receive a lethal injection?	28.63	4.41	27.43	4.57	.13

## Table 2 Internal locus of control by preference

statistically significant. The demographic variables of age, ethnic/racial identity, and gender were unrelated to all preferences.

# DISCUSSION

In Washington State in 1991, and in California in 1992, voters considered initiatives proposing that physicians and patients should be allowed to hasten death under certain circumstances. Each of these initiatives was rejected by the voters by a very small margin. In November of 1994, Oregon became the first U.S. state to pass such an initiative. Previous analyses have been unable to document clear support for the relationship between these initiatives and demographic variables. We undertook this study to explore whether certain psychological attitudes might account for the opposing views on this issue. Our hypothesis was that health locus of control is an important explanatory variable, in particular, that a strong internal locus of control may correlate with support for right to die legislation.

The results suggest that an internal locus of control may help explain support for right to die legislation. Specifically, those expressing attitudes supportive of physician assisted death for the hopelessly ill had significantly high internal locus of control scores than those who had less supportive attitudes. Currently, the U.S. population appears to be about evenly split between those who support and those who oppose such legislation. Previous analyses have been unable to document clear support for the relationship between these initiatives and demographic variables.

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Previous studies have shown that locus of control is significantly associated with a wide variety of other attitudinal and behavioral variables (Wallston, 1989, 1993). Further, health locus of control has been associated with a variety of health outcomes. For example, patients with end stage renal disease who had failed kidney transplantation were more depressed if they had an internal locus of control than those who had an external locus of control (Christenson *et al.*,1991). Several other studies have suggested that those with a sense of internal control are more likely to have more positive health outcomes than those with external focus of attention (Devins *et al.*,1992).

A series of studies suggests that some individuals are psychologically hardy (Kobasa, 1982) and that these individuals are more resistant to illness and tend to live longer. Perceived internal control is a central component of the hardiness construct. According to this formulation, the hardy personality attempts to exercise control and those less hardy give up. Our results suggest that those with a higher locus of control would also prefer to control end of life medical decisions. The hardiness theory argues that this is adaptive, yet we have little evidence that those opposed to physician assisted suicide live longer or experience less suffering.

We recognize several limitations with this study. The most prominent limitation is that the participants were not a representative sample from the general population. Instead, they were a convenience sample of university students. As a result, we are unable to assure that these results generalize to the population at large. We encourage additional research with a more representative sample of participants. Another limitation is that the differences in internal locus of control, although statistically significant, were small. For example, the significant differences represent seperations of about 2.5 points on a scale ranging from 6 to 36. The higher group had scores of approximately 28. Wallston (1989) considers scores of about 31 to be very high and scores in the range of 26 to 30 to be high. In other words, although our groups differed significantly, they tended to be in the same high range on the internality scale.

In summary, the public is approximately split in half over physician assisted suicide. Beliefs in internal locus of control may help explain these differences. We encourage more studies to identify the underlying explanations for differences in opinion on this divisive issue.

### Author's note

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