BLACK/WHITE DIFFERENCES IN ATTITUDES TOWARD PHYSICIAN-ASSISTED SUICIDE

Richard L. Lichtenstein, PhD, Kirsten H. Alcser, PhD, Amy D. Corning, MA, Jerald G. Bachman, PhD, and David J. Doukas, MD
Ann Arbor, Michigan

In 1994, as the Michigan legislature considered whether to continue a law banning physician-assisted suicide, we conducted a series of surveys on this topic. One of these surveys, conducted in Detroit, was designed to measure the attitudes of a largely black population toward physician-assisted suicide. Questionnaires were mailed to 500 residents of Detroit. The questionnaire described a plan for legalizing physician-assisted suicide, called Plan A, that incorporated eligibility standards and safeguards to minimize abuse. Attitudes on three issues were investigated: 1) Should physician-assisted suicide be banned or legalized? 2) Should voluntary euthanasia also be permitted? 3) Might respondents request legalized physician-assisted suicide for themselves?

Majorities of both whites and blacks supported Plan A; however, support was much lower among blacks than whites. Blacks were also less likely to support voluntary euthanasia or to envision asking for physician-assisted suicide themselves. Our analysis indicates that when age and sex are held constant, strength of religious commitment may account for much of the black-white difference in attitudes. We also consider alternative explanations based on cultural attitudes and degree of trust in the medical system. (*J Natl Med Assoc.* 1997;89:125-133.)

Key words: suicide ◆ physician-assisted suicide ◆ euthanasia ◆ blacks

The legalization of physician-assisted suicide has been debated in the medical ethics and legal literature for many years, and recently has entered the political arena as well. In 1991 and 1992, the citizens of Washington and California, respectively, voted in state referenda on the question of legalizing physician-assisted suicide and narrowly defeated the measures in both instances. In 1994, the citizens of Oregon narrowly passed a referendum that permits physician-assisted suicide to be carried out in accordance with specific procedures and regulations, but that law has been found unconstitutional by a federal court (*The New York Times.* August 4, 1995). Perhaps nowhere is the issue of physician-assisted suicide more controversial than in Michigan, where Dr Jack Kevorkian has assisted more than two dozen people in committing suicide. His activities have thrust the issue before the public, the courts, and the Michigan Legislature. In 1992, the Michigan Legislature passed Public Act 270 banning physician-assisted suicide. In addition, the

From the Department of Health Management and Policy, School of Public Health and the Survey Research Center, Institute for Social Research, University of Michigan and the Department of Family Practice, University of Michigan Medical School, Ann Arbor, Michigan. This research is not intended to advocate any particular point of view; it is investigator-initiated, funded by a grant from the Blue Cross and Blue Shield of Michigan Foundation. Requests for reprints should be addressed to Dr Richard L. Lichtenstein, University of Michigan, School of Public Health II, Dept of Health Management and Policy, 109 Observatory, Ann Arbor, MI 48109.

law called for the establishment of the Michigan Commission on Death and Dying, which was charged with making recommendations to the legislature about future laws related to assisted suicide.

To inform the legislature about public opinion concerning assisted suicide, the Program on Public Opinion and Health Policy at the University of Michigan's Institute for Social Research conducted a series of surveys of both citizens and practicing physicians in Michigan. Early results of these surveys were published elsewhere[1] and were available in time to inform members of the Michigan House of Representatives about public opinion prior to their vote on continuing the ban. Just before the vote, however, a judicial ruling found a common law prohibition against physician-assisted suicide in Michigan. Thus, need for further legislation on the matter was considered less urgent, and no law was passed during the 1994 legislative session.

The research carried out by the Program on Public Opinion and Health Policy included a survey conducted in the summer of 1994 in the city of Detroit, where three quarters of the population is black. This survey was undertaken for two reasons. First, a review of previous research on assisted suicide indicated that the attitudes of blacks toward assisted suicide differ substantially from those of whites.[2] Second, we felt it was important to be able to inform Michigan legislators about the attitudes of the largely black constituency in the state's largest city.

Previous studies on the attitudes of Americans toward physician-assisted suicide have found that levels of support for legalization of physician-assisted suicide are dramatically lower among blacks than among whites. Studies by Singh,[3] Ostheimer and Moore,[4] Finlay,[5] and Rao et al[6] all found substantial differences between blacks and whites in the degree of support for legalizing both physician-assisted suicide and voluntary euthanasia. National opinion poll data reported by Wood[7] indicate that support for legalizing physician-assisted suicide increased steadily from 1977 to 1989 among both groups; however, the data also show a persistent gap, with support among whites higher by 20 percentage points or more. In 1977, the percentage of whites supporting legalization was 65%; among blacks, support was at just 39%. In 1989, 71% of whites and 49% of blacks supported legalization. Studies of attitudes toward other end-of-life issues, such as the decision to use life-prolonging technology for patients with terminal conditions[8,9] and willingness to use advance directives and living wills for oneself or family members,[9] likewise show striking black-white differences, with blacks more resistant to limiting medical treatment.

Some attempts have been made to investigate why blacks and whites differ so markedly in their attitudes toward physician-assisted suicide, but the question cannot be answered adequately on the basis of research conducted to date. Singh,[3] Finlay,[5] and others have found that race differences persist even after controlling for education, age, socioeconomic status, and sex. Religious beliefs also have been investigated as a potential determinant of attitudinal differences, since "the most consistent finding in the literature...is that more religiously involved people are more likely to oppose the legalization of physician-assisted suicide."[5] However, despite the presence of fairly large differences in religious affiliation and religiosity between blacks and whites, it has been argued that such differences may not fully explain the difference in attitudes between the two groups.[5]

Our Detroit survey is the first we know of to examine the attitudes of a largely black population toward assisted suicide. This article reports the results of the survey on physician-assisted suicide and examines attitudinal differences between black and white Detroiters.

METHODS

Statewide Study of Physician-Assisted Suicide

The survey described here is one of a series of surveys conducted in 1994 on attitudes of Michigan citizens toward physician-assisted suicide. Statewide mail surveys were conducted during the spring and summer of 1994. Completed, usable questionnaires were received from 1799 of 2319 eligible respondents, producing a response rate of 77.6%. However, after examining the completed questionnaires from the statewide surveys, we found that blacks were inadequately represented among the respondents. Eighty-three (4.8%) of those who answered the question about racial/ethnic identity were black. Since the 1990 Census indicated that 12.8% of Michigan's adult population is black, and since previous work on attitudes toward physician-assisted suicide showed that the attitudes of blacks differ from those of whites, we decided to conduct a separate survey in a population with a large proportion of blacks.

The Detroit Survey

The Detroit sample, like the statewide sample, was selected from a commercially maintained sample frame based on national directory listings of adults and supplemented with information derived from administrative record sources. An advance letter was mailed to the total target sample of 500 Detroit residents in June 1994, followed 1 week later by a mailing containing the questionnaire and a cover letter. Second and third (certified) mailings were sent to nonrespondents, and all communication was personalized, as recommended by Dillman.[10] A short questionnaire was designed for the Detroit study to increase respondent participation. As in the statewide surveys, the questionnaire centered on a proposed plan for legalizing physician-assisted suicide, called "Plan A." A summary of Plan A, as shown in Table 1, was included in the questionnaire. This plan was adapted from the work of the Michigan Commission on Death and Dying[11]; it specified eligibility requirements and incorporated safeguards designed to minimize the risk of abuse. Thus, to be eligible for physician-assisted suicide under Plan A, a patient had to be an adult, mentally competent, diagnosed as having a terminal illness and expected to die within 6 months, and suffering from unacceptable pain. The safeguards stipulated that only the patient could request physician-assisted suicide and that the request had to be repeated and witnessed.

Table 1. Information on "Plan A" for Legalization of Physician-Assisted Suicide as Presented in the Detroit Questionnaire

Purposes of Plan A:

- To provide that terminally ill patients can request and receive a physician's assistance in hastening death
- To provide protection for physicians who voluntarily agree to fulfill such requests
- To provide safeguards against abuse

To be eligible for physician-assisted suicide under Plan A, a patient would have to be:

- An adult,
- Certified by a physician as being mentally competent and not suffering from clinical depression
- Terminally ill, with two physicians judging that death will occur within 6 months
- Suffering unrelenting pain at a level that the patient finds unacceptable

Additional safeguards that would be required under Plan A:

- The request for physician-assisted suicide would have to be made in writing by the patient (or in some other form, such as video-taped, if the patient is unable to write)
- The request for physician-assisted suicide would have to be witnessed by two persons having nothing to gain from the patient's death (they could not be relatives)
- A second request would have to be made, separated by a waiting period of at least 7 days
- A second physician would have to examine the patient and agree with the diagnosis
- Before physician-assisted suicide is provided, all reasonable pain control alternatives must be explained and offered to the patient
- No physician or health-care provider shall be required to have any involvement with physician-assisted suicide if he or she is opposed
- There would be criminal liability for assisting a suicide without following the physician-assisted suicide law
- "Suicide clinics" would be prohibited

Data Analysis

Dependent Variables. Three questions from the Detroit study provide measurements of different aspects of attitudes toward physician-assisted suicide. First, respondents were asked whether they thought the Michigan Legislature should legalize physician-assisted suicide according to Plan A or make all physician-assisted suicide illegal. Responses were conceptualized as representing a five-point scale of low to high support for legalization, from "Definitely make all physician-assisted suicide illegal" to "Definitely enact Plan A." Data from this question are used in the analyses presented below as the primary indicator of attitudes toward physician-assisted suicide.

A second question raised the issue of voluntary euthanasia. Respondents were asked whether, given the proposed Plan A safeguards and guidelines, they would favor expanding legalization so that physicians would be permitted to administer lethal treatment in cases in which the patient was unable to take the final action. Third, respondents were asked whether–assuming that physician-assisted suicide were legalized according to Plan A–they might request it for themselves if they were suffering from a terminal illness.

Independent Variables. Age, sex, education, and race of the respondents were obtained in a "person-

al background" section at the end of the questionnaire. Age was measured in exact years; information on education was recorded in seven ordered categories. Respondents also were asked to give their religious affiliation, if any. A measure of religiosity was obtained by asking respondents about the importance of religion in their lives; possible answers were "Very important," "Pretty important," "A little important," and "Not important."

RESULTS

Completed, usable questionnaires were obtained from 299 Detroit residents. Excluding from the target sample of 500 those who were known to be deceased, no longer living in Michigan, or whose mail had been returned as "undeliverable" at least twice, the overall response rate among the 476 eligible participants was 62.8%. Of these, 54% indicated that they were black and 32% identified themselves as white. Thus, a total of 86% of the Detroit respondents gave either black or white as their racial identification; 4% gave another identification, and 10% did not answer the question. Since this article focuses on attitudinal differences between blacks and whites, and since the number of respondents giving other racial or ethnic identifications is so small, the analyses presented below are based on the subsample of 257 respondents who identified themselves as either black (62% of the subsample) or white (38%).

Table 2 shows characteristics of the subsample of blacks and whites, and displays the relationship of those characteristics to attitudes toward assisted suicide and voluntary euthanasia. We used the correlation coefficient *eta*, a statistic that captures curvilinear as well as linear relationships, to examine the strength of the associations.

As the *eta* values in Table 2 indicate, race of respondent showed a strong relationship to attitudes toward physician-assisted suicide. When asked whether they thought the Michigan Legislature should make all physician-assisted suicide illegal or enact Plan A to permit physician-assisted suicide, support for legalization was significantly lower among black respondents than among whites: a total of 76% of whites thought physician-assisted suicide should "definitely" or "probably" be legalized compared with 56% of blacks. Figure 1 compares the proportion of blacks and whites giving each response to the question. Differences in religious affiliation and self-reported religiosity also showed significant relationships to attitudes toward physician-assisted suicide, with Baptists and those who said religion was "very important" in their lives the most likely to advocate keeping physician-assisted suicide illegal (Table 2).

Although race and religion appeared to show the strongest relationships to attitudes toward physician-assisted suicide in the Detroit study, Table 2 also indicates significant relationships between attitudes and respondents' sex and age. Nearly three quarters of men supported legalization of physician-assisted suicide in accordance with Plan A; just over half of the women in the sample did so. Women were both more opposed to legalization than were men and more uncertain as to whether physician-assisted suicide should be banned or legalized. Consistent with earlier research, the Detroit study also found that older respondents showed lower than average support for physician-assisted suicide.[12]

Other attitudes regarding physician-assisted suicide also showed strong race differences. Black respondents were less inclined than whites to expand physician-assisted suicide to allow physicians to administer lethal treatment. While 67% of whites would allow the doctor to take the final action when the patient is unable to do so, just 45% of blacks agreed that this should be possible. When asked whether they might ever request physician-assisted suicide for themselves, 52% of whites said they definitely or probably would, while only 37% of blacks did. Moreover, 29% of blacks said they definitely would not request physician-assisted suicide, more than double the proportion of whites (12%) who said they would definitely not (data not shown in the table).

Given the strength of the relationship between degree of religiosity and attitudes toward physician-assisted suicide that has been found previously, this relationship was explored as a possible explanation for the observed differences in attitudes toward physician-assisted suicide between blacks and whites. As expected, when level of religiosity is held constant, black-white differences in support for physician-assisted suicide are reduced. Figure 2 compares support for Plan A among blacks and whites within categories of importance of religion.

Regression Analysis

To examine in greater detail the effect of race and religion on attitudes toward physician-assisted suicide, a multivariate regression analysis was carried out. Responses to the question on legalizing physi-

Table 2. Characteristics of the Detroit Sample (N=257)*

Characteristic	Sample (%)	Probably/Definitely Legalize PAS (%)	Probably/Definitely Legalize Voluntary Active Euthanasia (%)	Probably/Definitely Request PAS for Self (%)
Race				
Black	62	56	45	37
White	38	76	67	52
Eta		.202†	.215†	.146†
Sex				
Male	47	73	65	53
Female	53	56	42	33
Eta		.185†	.229‡	.210†
Age (years)				
<30	9	77	59	36
30 to 39	14	65	54	46
40 to 49	15	80	74	54
50 to 59	17	59	50	46
60 to 69	20	67	48	39
70+	25	49	42	36
Eta		.219§	.207	.127
Education				
High school graduate or less	50	58	52	44
Some college or college graduate	35	70	53	41
Graduate work	15	70	57	39
Eta		.127	.035	.048
Religious affiliation				
Baptist	30	50	40	31
Other Protestant	25	59	48	38
Catholic	24	69	55	45
Other	13	78	63	56
None	8	90	84	65
Eta		.257†	.240†	.219§
How important is religion in your life?				
Not important	6	93	93	79
A little important	13	88	82	62
Pretty important	21	83	62	56
Very important	61	49	39	30
Eta		.380‡	.370‡	.324‡

Abbreviations: PAS=physician-assisted suicide.
*Percentages shown are based on valid cases only. There were 5 cases of missing data for education, 12 for religious affiliation, and 4 for importance of religion.
†$P<.01$.
‡$P<.001$.
§$P<.05$.

cian-assisted suicide in Plan A versus a ban were used as an interval-level dependent variable. Sex, age, and education were entered into the model as controls; race and an indicator of importance of religion are the independent variables of interest. The regression results are shown in Table 3. Once religiosity is included in the model, race, age, and sex no longer have a significant effect on support for

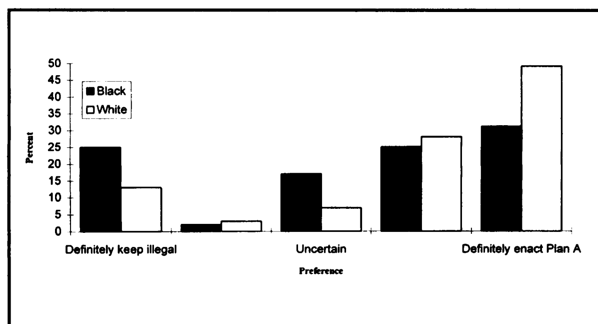

Figure 1.
Preferences for Plan A for physician-assisted suicide versus a ban, by race.

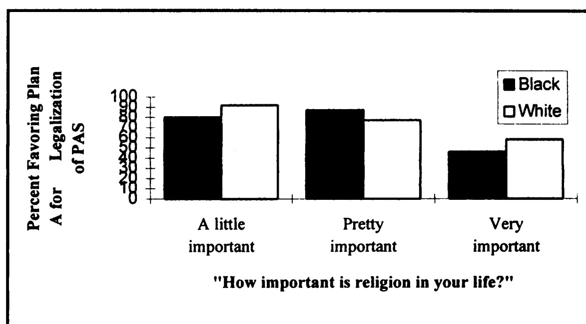

Figure 2.
Comparison of support for legalization of physician-assisted suicide among blacks and whites, by importance of religion (the "not important" category has been omitted from the chart due to small cell sizes).

legalization of physician-assisted suicide. Those who considered religion "very important," however, were less likely to support legalization ($P<.01$).

Respondent Comments

At the end of the questionnaire, respondents were invited to write comments on the issues raised and to note anything they felt to be important to the research. Thirty-eight percent of the respondents included a comment (with equal proportions among blacks and whites); most of those respondents took advantage of the opportunity to explain their views more extensively, often citing personal experience in grappling with the questions raised. Many also expressed appreciation for the chance to take part in the study and for its timely treatment of difficult but important issues.

There were only minor, nonsignificant differences in demographic characteristics between those who wrote comments and those who did not. In contrast, respondents who said religion was "very important" and those who were strongly opposed to legalization of physician-assisted suicide were especially likely to add a comment. Although we believe the subgroup that included comments is sufficiently representative of the entire sample to justify further analysis, the observed differences in propensity to write a comment should be borne in mind. Similarly, respondents who had experienced the serious or terminal illness of a close friend or relative, or who were themselves seriously ill, may have been more likely to include comments because the issues were more salient to them.

Comments in which respondents sought to explain or justify their views were coded according to the type of explanation offered. One quarter of those who wrote comments discussed the religious implications of legalizing physician-assisted suicide, most often noting that acceptance of any form of suicide ran counter to their fundamental religious beliefs: "I believe that only God can take and give life." The second most frequent type of comment raised the issue of the patient's quality of life as a concern. Some respondents perceived it as a factor that justified legalization of physician-assisted suicide:

> Once a person can't function for himself, forget it, you're history. Once a man or woman, twice a child–no way.

Others saw concern for quality of life as a consideration that needed to be weighed against religious beliefs about the immorality of any form of suicide:

> I don't believe in suicide or assisted suicide. Because God will forgive me for anything except self-murder. But now if push came to shove, I don't know what I would do, if I'm hurting so bad.

A greater proportion of blacks mentioned religious dictates, but whites were more likely than blacks to mention all other types of concerns. The proportion of blacks mentioning religious prohibitions against suicide or concerns about conflict with religious teachings was double the proportion of whites who raised the same issues.

DISCUSSION

This study confirmed several findings that have been reported in previous research on public atti-

tudes toward physician-assisted suicide. Majorities of both the white and black populations in Detroit were supportive of Plan A for legalizing physician-assisted suicide under carefully regulated and safeguarded circumstances. However, a fairly large disparity (20 percentage points) was found between blacks and whites in levels of support for Plan A. The gap between blacks and whites in support for legalization of physician-assisted suicide is notable both because of its magnitude and its stability over the past 17 years.[7] Blacks were also far less likely than whites to contemplate requesting physician-assisted suicide for themselves or to support voluntary euthanasia.

Analyses of the data from our statewide study indicate that attitudes toward assisted suicide are held quite firmly and are not changed easily by the survey process. In the statewide questionnaires, we systematically varied survey formats, question wordings, and the amount of information provided about the issues surrounding physician-assisted suicide. Yet results were remarkably similar regardless of the questionnaire used, indicating that attitudes on this issue are quite robust.[13] Moreover, the similarity of these findings to results of national surveys[14] suggests that while the actions of Dr Kevorkian and the debate within the Michigan Legislature may have heightened the Michigan public's awareness of the issue, these events probably have not changed attitudes toward legalization of physician-assisted suicide in any fundamental way.

Our analysis indicates that strength of religious commitment plays a major role in explaining differences in attitudes towards physician-assisted suicide and probably accounts for much of the reason why blacks and whites differ so markedly on this issue. Other research has shown both religious affiliation[3,15,16] and religiosity[3,5,12] to be consistent predictors of attitudes toward physician-assisted suicide. Our recent statewide surveys showed religiosity to be the single best predictor of an individual's support for or opposition to legalizing physician-assisted suicide.[13]

If strength of religious commitment is associated with opposition to laws permitting assisted suicide, one would expect that blacks would be more opposed to such laws than whites. Previous research has shown that religious commitment is much stronger in the black community than in the white community.[17] Indeed, our Detroit data show that 72% of blacks, in contrast with 40% of whites, said religion was "very important" to them, while only 9% of blacks and 38% of whites said religion was "not important" or "a little important." Thus, our findings in Detroit fully support the strong relationship between religiosity and attitudes toward physician-assisted suicide.

Table 3. Unstandardized and Standardized Coefficients for Regression of Responses to Plan A Question on Selected Variables (N=250)

Variables	b	SE_b	Beta
Sex			
Female (excluded=male)	−.281	.185	−.093
Age	−.008	.006	−.095
Education	−.039	.058	−.044
Race			
Black (excluded=white)	−.288	.196	−.093
Importance of religion (excluded= not important)			
Very important	−1.293*	.380	−.424
Pretty/a little important	−.461	.376	−.146
Constant	5.436		
R^2	.141		

*$P<.01$.

Both the literature and our respondents' comments provide the substantive arguments that connect religious teachings and opposition to physician-assisted suicide. Finlay[5] observed that strongly religious people may oppose assisted suicide because they take the commandment "thou shalt not kill" as an "absolute imperative." Early and Akers,[18] in a study on suicide among blacks in North Carolina, quote Southern Baptist pastors who stress that any form of suicide is an "unforgivable sin" that interferes with God's plan. Several comments written by our Detroit respondents indicate such beliefs. One respondent wrote:

> Only God should end someone's suffering. He is very capable of ending life. God have mercy on anyone believing they should have that right, besides, God is able to send cures for all illnesses, terminal or otherwise.

Another cautioned against "playing God": "He didn't ask none of us to help him be God or need us to take his place." Still others expressed the view

that suicide is an inappropriate way to escape from suffering because God knows how much suffering individuals can endure. One said: "The decision has already been made by God. He never puts more on us than we can bear," while another said, "I believe that the Lord gives you life and let the Lord take it, he knows just how much you can take."

Our data do not allow us to pursue in further detail the relationships between race, religion, and attitudes toward physician-assisted suicide. Our review of the literature on suicide among blacks, however, indicates that the condemnation of suicide by blacks not only represents a fundamental tenet of black religion but also seems to be a cultural manifestation of black heritage itself. National health data reveal that suicide rates among blacks are lower than they are among whites and have been for many years.[19] Early and Akers[18] underscored the cultural dismissal of suicide by blacks in the title of their paper, "It's a White Thing." In their study reporting the results of interviews with 25 black pastors, the authors indicate that the pastors found suicide:

> ...so alien to the black experience, religious and secular, that willingness to commit suicide runs directly counter to all that is implicit in what it means to be African-American.

One black pastor said:

> We been strugglin' all of our lives. The greater the sufferin'...you know...what we going to get will be better in heaven.

Likewise, Kastenbaum, quoted in Kalish,[20] concluded another study on suicide among older blacks as follows:

> Our impression is that maintaining life has required so much energy, endurance and resourcefulness that they cannot think of letting go just because things might get tough in one way or another.

Perhaps blacks' familiarity with struggle, the need to overcome hardship and to resist death, helps not only to explain black-white differences in attitudes toward suicide and physician-assisted suicide, but also to explain differences between blacks and whites with respect to other end-of-life treatment decisions. For example, studies have found blacks to be far more likely than whites to want life-prolonging treatments to be used in their care, even when their prognosis is seemingly hopeless.[8,9] Similarly, Koenig et al[21] found that blacks were more likely than whites to believe that people should live as long as they can and that pain and suffering would not justify dying. Others have found that substantially more blacks than whites say that how long you live is more important than how well you live.[8] In sum, capitulating to death seems to be foreign to black identity, and many blacks may regard physician-assisted suicide as just another form of such capitulation–and therefore oppose its legalization.

Our review of the literature raised another possible reason for racial differences in support for assisted suicide: blacks may be less likely than whites to trust physicians and the medical establishment. As a group that has experienced discrimination in other areas of life, blacks simply may not believe that physicians, or the health-care system in general, will follow the black patient's best interests when it comes to end-of-life care. In opposing the legalization of physician-assisted suicide, for example, blacks may fear that a policy developed to provide humane assisted suicide (for whites) will turn into a license to commit involuntary euthanasia (against blacks). Such lack of trust in the medical establishment may have originated with the disclosures about the Tuskegee syphilis study.[22] The Tuskegee study is still discussed in both popular and scientific publications as a reason why blacks feel they need to remain vigilant against the health-care system.[23,24] More contemporary data, which indicate that, *ceteris parabis*, blacks are less likely than whites to receive state-of-the-art medical care for serious heart disease, suggest that such vigilance and caution may still be warranted.[25,26]

Blacks' lack of trust in the health-care system has been explored by Callender et al[27,28] and Creecy and Wright[29] as one reason why blacks are significantly less likely than whites to donate their organs for transplantation. Callender et al observed that the low rate of donations by blacks may be related to fears that blacks will be declared dead prematurely so that their organs can be harvested. Creecy and Wright found that willingness to donate organs was "significantly associated with confidence in medical doctors." Others have found that blacks are significantly less likely than whites to complete advance directives or living wills, perhaps for the same reasons.[9]

CONCLUSIONS

Although majorities of both blacks and whites in Detroit favor legalizing assisted suicide, the strength

of support differs substantially between the two groups, and these differences are consistent with patterns found in studies of attitudes related to other end-of-life issues. Blacks, in greater proportions than whites, want to maximize the length of their lives. Any "premature" termination of life–through suicide, physician-assisted suicide, or even cessation of life support for terminally ill individuals–is resisted by blacks far more than by whites. Blacks also are far more reluctant than whites to explicitly empower physicians to make end-of-life decisions for them in situations involving advance directives, organ donations, and euthanasia. Differences in religious commitment between blacks and whites help explain the marked difference in attitudes toward physician-assisted-suicide between the two groups, but differences in cultural attitudes and in trust in medical care also can be other possible explanations for these racial differences. Future research should attempt to explore further the relative impact of each of these three factors as determinants of racial differences in attitudes toward physician assisted suicide and other end-of-life decisions.

Acknowledgments

The authors thank Fei Fei Metzler for assistance in conducting the surveys.

Literature Cited

1. Bachman JG, Doukas DJ, Lichtenstein RL, Alcser KH. Attitudes of Michigan physicians and public toward legalizing assisted suicide and voluntary active euthanasia. *N Engl J Med.* 1994;331:812-813.

2. Blendon RJ, Szalay US. The American public and the future of the right-to-die debate. In: Blendon RJ, Hyams TS, eds. *Reforming the System: Containing Health Care Costs in an Era of Universal Coverage.* New York, NY: Faulkner & Gray Inc; 1992:223-242.

3. Singh BK. Correlates of attitudes toward euthanasia. *Soc Biol.* 1979;26:247-254.

4. Ostheimer JM, Moore CL Jr. 'The correlates of attitudes toward euthanasia' revisited. *Soc Biol.* 1981;28:145-149.

5. Finlay B. Right to life vs the right to die: some correlates of euthanasia attitudes. *Sociology and Social Research.* 1985;69:548-560

6. Rao PVV, Staten F, Rao VN. Racial differences in attitudes toward euthanasia. *The Euthanasia Review.* 1988;2:260-277.

7. Wood F, ed. *An American Profile: Opinions and Behavior, 1972-1989.* Detroit, Mich: Gale Research Inc; 1990.

8. Garrett JM, Harris RP, Norburn JK, Patrick DL, Danis M. Life-sustaining treatments during terminal illness: who wants what? *J Gen Intern Med.* 1993;8:361-368.

9. Caralis PV, Davis B, Wright K, Marcial E. The influence of ethnicity and race on attitudes toward advance directives, life-prolonging treatments, and euthanasia. *J Clin Ethics.* 1993;4:155-165.

10. Dillman DA. *Mail and Telephone Surveys: The Total Design Method.* New York, NY: John Wiley & Sons; 1978.

11. *Final Report of the Michigan Commission on Death and Dying.* Legislative Service Bureau. Lansing, Mich: Michigan Commission on Death and Dying; 1994. MCDD FOIA DOC. A-902.

12. Ward RA. Age and acceptance of euthanasia. *J Gerontol.* 1980;35:421-431.

13. Bachman JG, Alcser KH, Doukas D, Lichtenstein RL, Metzler FF. *Public Judgment About Physician-Assisted Suicide and Euthanasia: Findings From 'Informed Surveys' of Michigan Citizens and Physicians.* Ann Arbor, Mich: Institute for Social Research; 1995.

14. Fear of dying. *Gallup Poll Monthly.* 1991;304:51-59.

15. Kalish RA. Some variables in death attitudes. *J Soc Psychol.* 1963;59:137-145.

16. Ostheimer JM. The polls: changing attitudes toward euthanasia. *Public Opinion Quarterly.* 1980;44:123-128.

17. Levin JS, Taylor RJ, Chatters LM. Race and gender differences in religiosity among older adults: findings from four national surveys. *J Gerontol B Psychol Soc Sci.* 1994;49:S137-S145.

18. Early KE, Akers RL. 'It's a white thing': an exploration of beliefs about suicide in the African-American community. *Deviant Behavior.* 1993;14:277-296.

19. National Center for Health Statistics. *Health, United States, 1994.* Hyattsville, Md: Public Health Service; 1995.

20. Kalish RA, Reynolds DK. *Death and Ethnicity: A Psychocultural Study.* Los Angeles, Calif: Ethyl Percy Andrus Gerontology Center, USC; 1976.

21. Koenig R, Goldner NS, Kresojovich R, Lockwood G. Ideas about illness of elderly black and white in urban hospitals. *Aging and Human Development.* 1971;2:217-225.

22. Jones JH. The Tuskegee legacy: AIDS and the black community. *Hastings Cent Rep.* 1992;22:38-40.

23. Thomas SB, Quinn SC. The burdens of race and history on black Americans' attitudes toward needle exchange policy to prevent HIV disease. *J Public Health Policy.* 1993;14:320-347.

24. Robinson LS. Curbing a sick practice. *Emerge.* October 1994:21-35.

25. Council on Ethical and Judicial Affairs. Black-white disparities in health care. *JAMA.* 1990;263:2344-2346.

26. Peterson ED, Wright SM, Daley J, Thibault GE. Racial variation in cardiac procedure use and survival following acute myocardial infarction in the Department of Veterans Affairs. *JAMA.* 1994;271:1175-1180

27. Callender CO, Bayton JA, Yeager C, Clark JE. Attitudes among blacks toward donating kidneys for transplantation: a pilot project. *J Natl Med Assoc.* 1982;74:807-809.

28. Callender CO, Hall LE, Yeager CL, Barber JB, Dunston GM, Pinn-Wiggins VW. Organ donations and blacks: a critical frontier. *N Engl J Med.* 1991;325:442-444.

29. Creecy RF, Wright R. Correlates of willingness to consider organ donation among blacks. *Soc Sci Med.* 1990;31:1229-1232.