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What Patient and Psychologist Characteristics Are Important in Competency for Physician-Assisted Suicide Evaluations?

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The practice of physician-assisted suicide (PAS) is currently legal in Oregon ([Oregon Death With Dignity Act, 1995](#)), Washington ([Washington Death With Dignity Act, 2008](#)), and Montana ([Baxter v. Montana, 2009](#)). In an effort to identify important characteristics of patients and clinicians involved in evaluations of competence to request PAS, 216 licensed psychologists from Oregon and Montana were surveyed regarding their attitudes toward PAS and their personal and professional experiences with suicide. They were also asked to make a competence decision for a patient requesting PAS based on a case vignette. Cognitive ability, as indicated by a question regarding the importance of cognitive ability and components of competence that rely on reasoning skills, was the only patient factor that significantly predicted competence decisions. Results also suggested that personal characteristics of clinicians, particularly whether someone in their personal life had ever attempted suicide and their willingness to support a family member's choice of PAS, influence their decision regarding the competence of the patient. Exploratory analyses also revealed that clinicians consider perceived burdensomeness to be of little importance when conducting a competence evaluation for PAS. In all, the largest effects were observed for the experimental vignette condition, clinician personal experience with attempted suicide, and clinician perceived importance of patient MacArthur Competence Assessment Tool for Treatment–Appreciation scores. The implications of these results are discussed, centering on recommendations for clinicians considering participating in competence evaluations for PAS and future directions for research.

Keywords: physician-assisted suicide, competence, forensic evaluations, evaluator bias, perceived burdensomeness

Physician-assisted suicide (PAS) is an alternative end-of-life decision in which physicians provide individuals with the means to end their life. The requesting party then decides if and when to use the means. However, the majority of states have statutes prohibiting assisted suicide. Statutes prohibiting PAS have been challenged in both District and Supreme Courts in multiple states (e.g., [Sampson v. Alaska, 2001](#); [Vacco v. Quill, 1997](#)) with limited success. Voters passed the [Oregon Death With Dignity Act \(ODDA; 1995\)](#) in 1994, and the law later became enforceable in 1997 ([Werth, Benjamin, & Farrenkopf, 2000](#)). According to

ODDA, an individual must be a resident of Oregon ([ORS 127.860 § 3.10](#)), at least 18 years of age ([ORS 127.805 § 2.01](#)), have a terminal illness which two physicians agree will result in death within 6 months ([ORS 127.820 § 3.02](#)), and be competent to make the decision ([ORS 127.830 § 3.04](#)) in order to qualify for PAS. Additionally, the individual must make two oral requests to his or her attending physician, made at least 15 days apart, and one written request ([ORS 127.840 § 3.06](#)). An additional waiting period of 48 hr must pass between the written request and the life ending prescription ([ORS 127.850 § 3.08](#)). Finally, the attending physician is required to offer an end to the PAS process after the second oral request, which the individual must refuse ([ORS 127.845 § 3.07](#)). The [Washington Death With Dignity Act \(2008\)](#) and [Montana Death With Dignity Act \(2009\)](#) statutes utilize the same verbiage and requirements as the ODDA (1995).

As noted by [Johnson, Cramer, Conroy, & Gardner \(2014\)](#), an integral aspect of the PAS process is ensuring that the patient is making an “informed decision.” A patient is deemed to be making an informed decision when the decision

is based on appreciation of the relevant facts and after being fully informed by the attending physician of: a) his or her medical diagnosis; b) his or her prognosis; c) the potential risks associated with taking the medication to be prescribed; d) the feasible alternatives,

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including, but not limited to, comfort care, hospice care, and pain control. (ORS 127.800 § 1.01.7)

This study reviewed the present guidelines for PAS as defined by the law and as suggested by evaluations of competence in other fields. With the law and professional guidelines as backdrops, we empirically evaluated psychologist perceptions of patient factors (e.g., cognitive abilities, mood disorder symptoms, motivation for request) as they may influence determinations of competence to request PAS. Given the lack of clarity or specific guidelines for psychologists' involvement in PAS, we reviewed the impact of personal characteristics and attitudes upon views of PAS, empirically testing whether these personal variables impact psychologists' determinations of competence to request PAS.

Involvement of Psychologists in Evaluations of Competence

According to ODDA, a psychologist or psychiatrist may be requested to make an evaluation of an individual's competency to continue with the process of PAS (Johnson et al., 2014). However, such mental health professionals are only involved in the process if explicitly called upon by an attending or consulting physician believing the individual's decisional capacity is impaired by a "psychiatric or psychological disorder or depression" (ORS 127.825 § 3.03). If this occurs, a psychologist or psychiatrist is called upon to make an evaluation of the individual's competency to continue with the process of PAS. There are presently no guidelines or recent court cases to provide legal clarification of what constitutes decisional competency in PAS (Johnson et al., 2014; Werth et al., 2000). The American Psychiatric Association remains neutral on the issue of PAS and only outlines ways in which psychologists may be helpful in future research and educating others about PAS (American Psychiatric Association, 2000). Furthermore, no formal position statements or guidelines are available from the American Medical Association (2000), despite attending physicians having the most responsibility under the current statute. Opinion 2.211 of the American Medical Association's code of medical ethics refers explicitly to PAS, stating, "allowing physicians to participate in assisted suicide would cause more harm than good" (para. 2).

Fortunately, the requirement of evaluating an individual's competence before continuing a legal or clinical process is not unique to PAS. Mental health professionals are frequently asked to assist in evaluations of competence for purposes other than PAS. For example, evaluations of competence to stand trial and competence to consent to treatment are common in legal and clinical contexts. Such competence evaluations have established key precedents to be considered in PAS competence evaluations (Johnson et al., 2014). Evaluations of competence typically assess four domains: factual understanding of information related to the decision, rational understanding of information related to the decision, the ability to communicate with others, and an appreciation of the current circumstance and possible outcomes (Johnson et al., 2014). Additionally, assessments begin with the assumption that the individual is competent and this assumption is only overturned in the presence of sufficient evidence (Werth et al., 2000). The assumption of competence is not overturned due solely to the presence of a mental illness or mental health treatment regimen (Werth et al.,

2000). These precedents provide a needed basis to guide competence to request PAS evaluations (Johnson et al., 2014). However, the legal definitions of key terms (e.g., capacity) remain unclear and mental health professionals are allotted significant freedom to determine what amount of behavioral and emotional deficits constitute incompetence (Werth et al., 2000). Further, Johnson and colleagues (2014) note that the field of psychology has a long-standing history of viewing suicidal ideation as a symptom of mental illness that may preclude psychologists' ability to perform PAS evaluations without clearer standards for evaluations. An important distinction in viewing suicidal ideation in a PAS context is that the nature of some thoughts of death or suicidal ideation may not reflect pathology, however. For instance, a terminally ill individual may experience such thoughts in the form of embracing or accepting the end of life.

Farberman (1997) proposed that psychologists should serve as protectors of the patient's rights and provide support for the patient's family. However, Farrenkopf and Bryan (1999) stated that psychologists should first clarify the reason for the referral when involved in the PAS process. Reasons for referral may be an evaluation of competence as described by the legal statutes, but also frequently include treatment aimed at relieving symptoms of a disorder or improving patient competence (Johnson et al., 2014). Aside from the legal statute issuing the directive to complete an evaluation of competence, the psychologist apparently has the freedom to determine the extent of his or her involvement, with one notable exception. The *Specialty Guidelines for Forensic Psychologists* (Committee on the Revision of the Specialty Guidelines for Forensic Psychology, 2011) specifically prohibit dual treatment and assessment roles of the same client.

This freedom of choice renders standard ethical considerations far more complex than with usual cases. An overarching concern, for example, is that mental health and other professionals may consider conducting a PAS evaluation completely unethical on grounds such as violating American Psychological Association (APA; 2010) ethical standards like *Avoiding Harm* (standard 3.04; Johnson et al., 2014). That is, the practicing clinician may believe that the ultimate outcome, facilitating or hastening death, represents harm to the patient. Further, as reviewed in depth by Johnson and colleagues (2014), more complicated ethical concerns may arise including, but not limited to, *Conflict of Interest* (Standard 3.06), *Third-Party Request for Services* (Standard 3.07), *Maintaining Confidentiality* (Standard 4.01), and *Bounds of Competence* (Standard 2.01). *Request for Services* provides a good example of the ethical gray areas clinicians may encounter, as it is not currently clear whether the actual client is the patient requesting PAS or the attending physician making the referral (Fenn & Ganzini, 1999). Further complicating the issue is clarifying that this relationship is crucial, as Johnson and colleagues (2014) noted that limits of confidentiality vary depending on which party is identified as the client. Indeed, the ethicality of direct communication with the patient and their family hinges on which party is declared the client being served (Fenn & Ganzini, 1999). The identification of the client will also determine whether additional services (e.g., therapy, patient advocacy) should be given to the patient (Johnson et al., 2014).

Since Oregon legalized PAS, Washington (*Washington Death With Dignity Act*, 2008) and Montana (*Baxter v. Montana*, 2009; *Montana Death With Dignity Act*, 2009) have passed similar

legislation using the same framework and definitions as the ODDA. This recent legalization, in tandem with a clear lack of professional guidelines, has led to numerous legal and ethical dilemmas regarding PAS for practicing psychologists in these states (for a full review, see Johnson et al., 2014). Indeed, there appears to be a consensus in the research literature that the training psychologists receive in assessment, psychopathology, cognitive impairment, and the concept of capacity (especially those with a specialty in forensic psychology), make them uniquely qualified to assist in determining whether a patient is capable to consent to PAS (Farberman, 1997; Farrenkopf & Bryan, 1999; Werth et al., 2000; Werth, Lewis, & Richmond, 2009). However, ambiguity in the ethical and legal roles and responsibilities of psychologists involved in cases of PAS may lead psychologists to rely on their own beliefs regarding the practice or their clinical judgment for guidance. As a result, it is imperative to examine psychologists' personal and professional beliefs about PAS.

Perceptions of PAS Among Mental Health Professionals

DiPasquale and Gluck (2001) surveyed psychologists and psychiatrists in New Mexico to determine their attitudes toward PAS and willingness to assist in the process. Overall, 75% of respondents were in favor of legalizing PAS and 60% were willing to perform an evaluation of capacity if necessary. Additionally, 55% indicated that they would be willing to provide other assistance in the process if it were a legal practice. Willingness to participate in PAS was positively correlated with several personal characteristics: desire for PAS to be a legal option for themselves should they fall ill, belief in the possibility of suicide being a rational decision, lower ratings of religiosity, and personal experience with someone who suffered from a terminal illness. The overwhelming majority (86%) of respondents indicated that a psychological evaluation to determine decisional capacity should be required in cases of PAS. However, only 57% were confident in their ability to accurately detect depression in a patient making a request for PAS, 32% were uncertain, and 11% were not at all confident in their ability to do so. This relatively low rate of clinicians being confident in assessing depression is actually higher than other similar (yet limited) studies in the literature. For instance, Lloyd-Williams and Payne (2002) reported that 79% of nurses surveyed felt their depression assessment skills were poor in the context of working with palliative care patients. Likewise, Palmieri and colleagues (2008) noted that approximately 87% of health professionals desires improved general suicide risk assessment skills. The low rates of clinician comfort in these contexts may be due to lack of sufficient training and experience, or due to the high risk of death in these particular populations.

It has been proposed that mental health professionals with forensic training may have unique training and experience to evaluate competence in requests for PAS (Ganzini et al., 2000). In a survey of 290 members of the American Academy of Psychiatry and the Law, forensic psychiatrists were asked about their attitudes toward PAS. The majority of forensic psychiatrists sampled had professional experience with competence evaluations and end-of-life decisions, with 74% having conducted competence evaluations for individuals refusing life sustaining treatment. They were also found to have significant personal experience with end-of-life

issues. Fifty-four percent indicated that they had personally cared for a family member or close friend who was suffering from a terminal illness and 67% reported having witnessed the suffering of a dying family member or friend (Ganzini et al., 2000). Eighty percent of respondents expressed the belief that suicide was ethical under some or all circumstances; however, only 66% considered PAS to be an ethical practice. These responses mirror previous results in which PAS was viewed as less ethical than suicide. Similar to the results of DiPasquale and Gluck (2001), low religiosity and White ethnicity were positively correlated with moral acceptability of PAS (Ganzini et al., 2000).

Forensic psychiatrists were also asked to provide their opinions on the necessity of competence evaluations in requests for PAS and whether psychiatrists should be involved in the process (Ganzini et al., 2000). Approximately 39% percent of respondents indicated that an evaluation should be required in every request for PAS, 22% suggested the evaluation be required in some cases, 12% that the evaluation should be recommended but not required, and 3% that the evaluation was not necessary as a safeguard. The authors also found that individuals who had responded that PAS was never morally acceptable were also advocates for an evaluation involving more extensive review of collateral information and a higher standard for competence compared to psychiatrists indicating that PAS was either sometimes or always acceptable.

Perhaps the most relevant study of personal and professional perspectives on PAS was conducted with 461 psychologists from Oregon (Fenn & Ganzini, 1999). Approximately 55% of respondents indicated that suicide was morally acceptable in some circumstances, 36% believed the morality of suicide is an individual choice, and 9% reported that suicide is never acceptable. When asked about the moral acceptability of PAS, 85% indicated the practice was acceptable under some circumstances, 6% believed it to be an individual choice, and 9% that it is never acceptable. Eighty-two percent of the Oregon psychologists surveyed believed that they would consider PAS as end-of-life alternative under certain circumstances. The most common conditions under which PAS would be considered an alternative were pain and suffering, loss of mental faculties, poor quality of life, impossibility of recovery, terminal diagnosis, burdening family and friends, loss of physical mobility, financial burden, and loss of independence. The authors also found that opposition to PAS was predicted by six personal values and characteristics: no personal consideration of PAS as an end-of-life alternative, belief that suicide is an immoral act, belief in a physician's duty to preserve life, viewing patient autonomy and self-determination as less important than maintenance of life, concern regarding the potential for abuse, and younger age (Fenn & Ganzini, 1999).

The existent, albeit meager, literature suggests personal values and characteristics affect psychologists' beliefs about the moral acceptability of PAS (DiPasquale & Gluck, 2001; Fenn & Ganzini, 1999; Ganzini et al., 2000; Werth, 1999). Individual responses from Oregon psychologists, such as "the first thing I would do is try to talk the patient out of committing suicide," and others reporting that they would set a low threshold for competence suggest that these personal values may interfere with the objectivity of evaluators (Fenn & Ganzini, 1999). Given these results and the absence of explicit professional guidelines, it is quite possible that psychologists' personal beliefs and experience significantly

influence their cognitive processes during psychological evaluations of competence.

Present Study

This primary purpose of this study was to identify patient factors and components of competence that are the most important or influential when psychologists are asked to make a determination of competence for a patient requesting PAS. In regard to patient factors, odds of making a recovery (Achille & Ogloff, 1997; Fenn & Ganzini, 1999; Wilson et al., 2007), mental alertness (Achille & Ogloff, 1997; Fenn & Ganzini, 1999), full consideration of treatment options (Achille & Ogloff, 1997), psychological distress (Achille & Ogloff, 1997; Wilson et al., 2007), physical suffering (Fenn & Ganzini, 1999; Wilson et al., 2007), stability of request (Achille & Ogloff, 1997), and perceived burdensomeness (Fenn & Ganzini, 1999; Wilson et al., 2007) have been found to be important in others' considerations of a patient's competence. When competence is legally questioned, the concept is generally thought to be comprised of four components: communication of a choice, factual understanding of the situation and decision, appreciation of situation and possible consequences, and a rational understanding (Farberman, 1997; Farrenkopf & Bryan, 1999; Ganzini, Leong, Fenn, Silva, & Weinstock, 2000; Sears & Stanton, 2001; Werth et al., 2000). Although all of the above have been suggested to be influential in making a determination of competence, there has been no actual investigation of how important they may be in a psychologist's decision making. This study provided participants with several patient factors and components of competence, and asked them to rate the importance of each in their determination of competence.

Hypothesis 1: There will be a significant main effect of experimentally manipulated competence condition on likelihood of rating the patient competent. Specifically, patients recommended as competent will be associated with testing showing the following: higher IQ scores, higher scores on the MacArthur Competence Assessment Tool for Treatment (MacCAT-T) components of competence, and lower levels of depression.

The second purpose of the present study was to examine whether personal characteristics of psychologists and their attitudes toward PAS influenced their determination of competence for a patient in the process of making a request for PAS. Previous research identifies religiosity (Achille & Ogloff, 1997; Cicirelli, 1997; DiPasquale & Gluck, 2001; Ganzini et al., 2000; Wilson et al., 2007), African American ethnicity (Cicirelli, 1997), and lower socioeconomic status (Cicirelli, 1997) to be negatively correlated with PAS as an acceptable end of life decision. White ethnicity (Cicirelli, 1997; Ganzini et al., 2000), higher socioeconomic status (Cicirelli, 1997), younger age (Fenn & Ganzini, 1999; Wilson et al., 2007), male sex (Cicirelli, 1997), experience with death (DiPasquale & Gluck, 2001; Wilson et al., 2007), and the desire for PAS to be a legal option for personal use (DiPasquale & Gluck, 2001; Fenn & Ganzini, 1999) have been found to be positively correlated with more favorable views of PAS.

Hypothesis 2: There will be significant main effects of personal characteristics of participants on competence decisions,

regardless of the competence condition to which they are assigned. Specifically, significant negative effects are expected between both religiosity and age on the likelihood of recommending competence. Significant positive effects are expected between both experience with death (i.e., personal and professional experience with suicide and physician assisted suicide) and personal desire for PAS (i.e., desire for PAS for own use or willingness to support client or family member's request for PAS) on likelihood of recommending competence.

To further our understanding of PAS evaluations, we will identify clinician perceived importance of patient test scores and other characteristics as they influence competence decisions.

Method

Participants

Participants were drawn from a random mailing sample of 1,000 participants from a total bank of over 2,400 licensed psychologists in the state of Oregon and over 250 licensed psychologists in the state of Montana. Names, mailing addresses, and statuses (i.e., active, retired, deceased) were obtained from the Board of Psychologist Examiners in both states. Only psychologists with an active status were chosen for participation in this study. Psychologists from Washington were not included in this study because contact information of licensed practitioners was unavailable. A total of 216 participants of the original 1,000 contacted responded with complete and usable data. However, 40 of the original contacts were sent back due to invalid mailing addresses, leaving the total possible sample at 960. Therefore, the overall response rate was 22.5% (216/960). Table 1 details participant demographics and attitudinal variables.

Materials

Vignettes. Patient descriptions were created using information from the 2011 Oregon's Death With Dignity Act Annual Report (Oregon Public Health Division, 2012). The characteristics of each person that has requested and subsequently died from ingesting a lethal dose of medication have been published since 1998 and updated annually. The most prevalent characteristics were combined to create demographic information for the patient in the vignettes. The following information was held constant across conditions: name (John Smith), sex (male), race (White), age (71; median age according to annual report), marital status (married), level of education (baccalaureate degree), underlying illness (terminal lung cancer), prognosis (death within six months of diagnosis; ORS 127.800 § 1.01), and end of life care (enrolled in hospice care).

The degree of patient competence was manipulated by varying scores on several instruments that assess components of competence across conditions. An intelligence score has been suggested as a means by which cognitive capacity can be measured when conducting competence evaluations (Lally, 2003). Thus, participants were provided with a Full Scale IQ score obtained from the Wechsler Adult Intelligence Scale-Fourth Edition (WAIS-IV). The competent patient received a score of 115 (high-average

Table 1
Descriptive Statistics for Participant Demographics

Demographic variables	<i>n</i>	%	<i>M</i>	<i>SD</i>
Clinician age			51.5	11.2
Clinician race				
White	202	93.5		
Hispanic	3	1.4		
Asian/Pacific Islander	3	1.4		
Other	7	3.2		
Male	86	39.8		
Female	125	57.9		
Licensed in Oregon	192	88.9		
Licensed in Montana	22	10.2		
Years of practice			18.3	10.5
Rating of religiosity ^a			4.2	1.9
# of suicidal patients within last year			7.6	17.3
# of patients who attempted suicide in career			16.8	89.0
# of patients who completed suicide in career			.7	1.1
# of patients who underwent PAS process			.2	2.1
Personal experience with attempted suicide	114	52.8		
Personal experience with completed suicide	94	43.5		
Personal experience with PAS process	9	4.2		
Participant attitudinal variables				
Rating of support for PAS			5.7	1.6
Likelihood of choosing PAS for self			4.4	1.8
Likelihood of supporting family member's PAS			5.4	1.6
Ratings of importance for competence determination				
Irreversibility of condition			6.3	1.5
Cognitive ability			6.1	1.3
Physical suffering			6.2	1.3
Mental suffering			5.7	1.4
Perceived burdensomeness			3.7	1.7

Note. PAS = physician-assisted suicide. Participant attitudinal variables scored on a 7-point scale in which greater scores represent greater willingness/support/importance. Where demographic totals do not reach the total *n* of 216, participant missing data account for the rest of the sample.
^a Higher scores on rating of religiosity (7-point scale) indicate greater religiosity.

range), the ambiguous patient was given a score of 100 (average range), and the incompetent patient earned a score of 85 (low-average range; Wechsler, 2008).

The ODDA specifically names depression as a condition which may impair a patient's decisional capacity and cause the attending physician to seek a psychiatric consult (ORS 127.825 § 3.03). Further, previous research suggests that the presence of psychological distress or depression can influence how competent a patient is perceived to be (Ganzini et al., 2000). As a result, level of depression was varied across vignettes via the Beck Depression Inventory–Second Edition (BDI-II; Beck, Steer, & Brown, 1996). The BDI-II is a 21-item self-report instrument designed to measure the severity of depressive symptoms in adults and adolescents. It was developed to assess symptoms that correspond to criteria for depressive disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000; Beck, Steer, & Brown, 1996). The competent patient received a score of 9 on the BDI-II (minimal range), the ambiguous patient a score of 20 (moderate range), and the incompetent patient a score of 30 (severe range; Beck et al., 1996).

According to the ODDA, a patient is considered to be making an “informed decision” regarding their request for PAS if he or she

has an understanding and appreciation of their medical diagnosis, prognosis, risks of taking the prescribed medication, feasible alternative treatment options, and is able to communicate a final treatment decision to the health care provider (ORS 127.800 § 1.01.7; ORS 127.800 § 1.01). An informed decision, as defined by the ODDA, is similar to four prongs of competence that are commonly assessed in evaluations of competence for purposes other than PAS (e.g., Farberman, 1997; Werth et al., 2000). The MacCAT-T is a structured interview protocol created to assist physicians and health professionals in determining a patient's capacity to consent to treatment and it assesses the four prongs of competence (Grisso & Appelbaum, 1998). The creators of the instrument have reportedly acknowledged that the MacCAT-T could be used to evaluate competence of patients requesting PAS (Werth et al., 2000). Therefore, study participants were provided with a short description of the components of the MacCAT-T and the patient's scores on each category. The competent patient earned the following scores: Understanding = 6 (out of 6), Appreciation = 4 (out of 4), Reasoning = 7 (out of 8), and Expressing a Choice = 2 (out of 2). The ambiguous patient received the following scores: Understanding = 4 (out of 6), Appreciation = 3 (out of 4), Reasoning = 5 (out of 8), and Expressing a Choice = 1 (out of 2). The incompetent patient received the following scores: Understanding = 2 (out of 6), Appreciation = 2 (out of 4), Reasoning = 3 (out of 8), and Expressing a Choice = 0 (out of 2).

The competence decision was assessed in two ways. First, participants were asked to make an ultimate decision regarding competence and forced to choose between “Competent” and “Incompetent,” as this type of decision is similar to that actually made by mental health professionals consulting on competence evaluations in PAS requests. They were then asked to rate on a 7-point scale the extent to which they believe the patient is competent. Participants also rank ordered (1–6) the testing information according to how influential they believe it was in their decision. Lastly, importance ratings were obtained for each assessment component (1 = *not at all important*; 7 = *very important*).

Survey. Participants completed a demographic and attitudinal survey. Demographic information collected included state of licensure, years of practice, sex, age, race,¹ and religious/spiritual affiliation. Additionally, ratings of religiosity (i.e., “How religious/spiritual are you?”) were made on a 7-point scale (1 = *not at all*; 7 = *very*). Participants were also asked to estimate the number of suicidal patients they have encountered in their careers and indicate whether they have any personal experience with suicide (e.g., “Has anyone in your personal life ever completed suicide?”). They were also provided with a list of competence evaluations (i.e., competency to stand trial, for execution, to consent to treatment, and to request PAS) and asked to estimate how many of each they have conducted in addition to rating how willing they would be to perform the evaluation using a seven-point scale (1 = *not at all willing*, 7 = *very willing*).

Several questions focused on experience with PAS, such as how many patients or members of the participant's personal life have ever requested PAS. Participants were then asked to respond to

¹ Participant race was ultimately dropped from statistical analyses due to limited variability rendering cell sizes too small to examine between-groups differences of race on competence decisions.

numerous questions designed to assess their attitude toward PAS, such as "What is your opinion regarding physician assisted suicide?" (1 = *strongly oppose*; 7 = *strongly support*) and "How likely would you be to choose physician-assisted suicide as an end of life alternative for yourself?" (1 = *never*; 7 = *definitely*). Following attitudinal questions, participants rated the importance of patient factors (e.g., cognitive ability, physical suffering, mental suffering) on a 7-point scale (1 = *not at all important*; 7 = *very important*).

Procedure

Packets were mailed to 1,000 randomly selected licensed psychologists in Oregon and Montana. All packets contained a document of informed consent, survey, and one randomly assigned case vignette. Participants were randomly selected using a random number generator and then randomly assigned to one of three competence conditions: competent, incompetent, or ambiguous. Participants were asked to complete the survey, read a brief vignette, and provide a competence decision.

Results

Pilot study. To ensure successful manipulation of perceived competence between experimental competence conditions, a pilot study was conducted using 25 doctoral-level graduate students and doctoral-level faculty. Eight participants comprised the competent and incompetent conditions, while there were nine participants in the ambiguous condition. Each participant was provided one of three randomly assigned competence condition vignettes (i.e., incompetent, ambiguous, or competence; see details of manipulation in the Method section). Each participant rated the perceived competence of their case example on a 7-point scale (1 = *not at all competent*; 7 = *completely competent*). A one-way analysis of variance (ANOVA) was conducted to ensure the pattern of competence ratings was consistent with the expected pattern of the manipulation, such that the incompetent condition would receive the lowest ratings, ambiguous would receive the next highest, and the competent condition would receive the highest ratings. Results indicated that the manipulation was successful in the expected direction, $F(2, 22) = 6.44, p = .006$. LSD post hoc tests showed the following rating scores for each condition (all p values range from .002 to .08 for between-groups comparisons): incompetent ($M = 3.38, SD = 1.06$), ambiguous ($M = 4.67, SD = 1.66$), and competent ($M = 5.88, SD = 1.36$). Although all p values were not less than .05, the manipulation was deemed appropriate given the successful expected pattern of competence ratings. Low statistical power accounts for the p values exceeding .05 (Cohen, Cohen, West, & Aiken, 2003).

Hypothesis 1. For all hypothesis evaluations, only participants who provided complete data for the respective analysis were included.² A chi-square test was conducted to determine whether there were significant differences in the dichotomous competence decisions between the three experimental competence conditions. Of the 180 clinicians who supplied an ultimate decision of competence to request PAS,³ 110 clinicians (61.1%) indicated that the patient was competent, whereas 70 clinicians (38.9%) indicated that the patient was incompetent (odds ratio [OR] = 1.57). The percentage of clinicians who declared the patient competent varied

according to experimental competence condition, $\chi^2(2, N = 180) = 88.1, p < .001$. Sixty-nine clinicians (97.2%) in the competent condition declared the patient to be competent whereas two clinicians (2.8%) gave an incompetent determination ($OR = 34.50$). Thirty-two clinicians (61.5%) within the ambiguous condition declared the patient to be competent, whereas 20 clinicians (38.5%) gave an incompetent determination ($OR = 1.60$). Finally, nine clinicians (15.8%) declared the patient to be competent in the incompetent condition, whereas 48 clinicians (84.2%) gave an incompetent determination ($OR = .19$). Overall, clinicians were more likely to give a competent determination in the competent condition versus the ambiguous condition ($OR = 1.58$) and incompetent condition ($OR = 2.52$). Clinicians were also 1.59 times as likely to give a competent determination in the ambiguous condition versus the incompetent condition.

A one-way analysis of variance (ANOVA) was also conducted to determine whether there were significant differences in the continuous ratings of competence between the three experimental conditions. As expected, there was a significant main effect for experimental competence condition when assessing competence ratings, $F(2, 195) = 188.95, p < .001, \eta_p^2 = .66$. Post hoc analyses using the LSD criterion revealed that all experimental conditions significantly differed from one another ($ps < .001$): Clinicians in the competent condition ($M = 6.36, SD = .94$) rated the patient as more competent than clinicians in the ambiguous condition ($M = 4.51, SD = 1.20$) or the incompetent condition ($M = 2.80, SD = 1.14$), $ds = 1.75$ and 2.44 , respectively. Additionally, clinicians in the ambiguous condition rated the patient as more competent than clinicians in the incompetent condition, $d = 1.07$.

Exploratory analyses: Perceived importance of patient characteristics. A binary logistic regression model predicting clinicians' ultimate decision on competence to request PAS was conducted. Predictor terms entered into the model were experimental competence condition (competent, ambiguous, incompetent) and ratings of importance (greater scores indicate greater importance) regarding scores on the WAIS-IV, BDI-II, and four component scores on the MacCAT-T (Understanding, Appreciation, Reasoning, Expressing a Choice). Consistent with guidance provided by statistical literature (e.g., Cohen et al., 2003; Peng, Lee, & Ingersoll, 2002), we report overall model effectiveness (Wald χ^2), goodness-of-fit (Hosmer and Lemeshow test), and individual predictor significance tests (β , Wald chi square, and odds ratios).

Table 2 displays predictor-level summary statistics for the logistic regression model. The set of predictor variables exerted a significant effect on clinicians' determinations of competence, Wald's $\chi^2(8) = 121.64, p < .001$, Cox and Snell $R^2 = .51$, Nagelkerke $R^2 = .69$. The model also exhibited acceptable goodness-of-fit, $\chi^2(8) = 14.45, p = .07$. Results showed that, for every 1-point increase in the perceived importance of the MacCAT-T Appreciation score, a clinician was 2.05 times as likely to declare the patient competent. Conversely, for every

² Note that only significant effects are reported in text due to the number of analyses conducted. Full statistical tests are either viewable in the tables, or available from the first author upon request.

³ Listwise deletion was necessary because 36 of 216 respondents did not provide the ultimate outcome; therefore, other data imputation methods were unable to be implemented.

Table 2
Logistic Regression Model Predicting Competence Decisions by Perceived Test Score Importance

Predictor	β	$SE \beta$	Wald (df)	p	OR	95% CI
Competent condition ^a	6.55	1.20	29.95 (1)	<.001	701.71	[67.11, 7336.79]
Ambiguous condition ^a	2.19	.56	15.16 (1)	<.001	8.95	[2.97, 26.97]
Ratings of importance to competence						
WAIS-IV	-.02	.16	.02 (1)	.90	.98	[-.72, 1.34]
BDI-II	-.23	.15	2.30 (1)	.13	.79	[-.59, 1.07]
MacCAT-T						
Understanding	.01	.31	<.01 (1)	.97	1.01	[-.55, 1.86]
Appreciation	.72	.32	5.21 (1)	.02	2.05	[1.11, 3.80]
Reasoning	-1.03	.34	8.91 (1)	.003	.36	[-.18, .70]
Expressing a Choice	-.07	.23	.12 (1)	.73	.93	[-.60, 1.44]

Note. β = β weight; OR = odds ratio; CI = confidence interval; WAIS-IV = Wechsler Adult Intelligence Scale–Fourth Edition; BDI-II = Beck Depression Inventory–Second Edition; MacCAT-T = MacArthur Competence Assessment Tool for Treatment. Ratings of importance were scored on a 7-point scale in which greater scores represent greater perceived importance.

^a Incompetent condition selected as the reference group.

1-point increase in the perceived importance of the MacCAT-T Reasoning score, a clinician was 0.36 times as likely to declare the patient competent.

A one-way analysis of covariance (ANCOVA) was conducted to determine if a similar pattern occurred in clinicians' rating scale of competence. Experimental competence condition (competent, ambiguous, incompetent) was entered as a between subject variable with clinician ratings of the importance of WAIS-IV, BDI-II, and the four component scores of the MacCAT-T entered as covariates. Experimental competence condition significantly affected clinicians' ratings of competence, $F(2, 180) = 203.06$, $p < .001$, $\eta_p^2 = .69$. Further, the perceived importance of the MacCAT-T Reasoning score explained a significant amount of variance in clinicians' ratings of competence, $F(1, 180) = 5.03$, $p = .03$, $\eta_p^2 = .03$, $B = -.21$. The more important a clinician perceived the Reasoning score to be, the less likely the clinician was to rate the patient as competent.

Hypothesis 2. Participant characteristics were expected to yield main effects on competence decisions regardless of the experimental condition to which participants were assigned. All participant variables were first analyzed to ensure that assumptions of normality were met. Personal experience with PAS (skewness = 4.62, kurtosis = 19.52) and the number of patients that have gone through the PAS process (skewness = 13.43, kurtosis = 188.79) were dropped from further analyses due to lack of variability and unacceptably high skewness and kurtosis values. In order to limit observed skewness in the number of suicidal patients within the last year (range: 0–150) and the number of patients that attempted suicide in career (range: 0–1,000), outliers reporting 75 suicidal patients in the past year or more were excluded from all further analyses. Outliers reporting 800 or more patient suicide attempts in their career were also excluded from analyses. All other participant characteristic variables met the requisite assumptions of normality.

A binary logistic regression model predicting clinicians' ultimate decision on competence to request PAS was conducted. Predictor terms entered into the model were clinician age, religiosity ratings, number of suicidal patients within the last year, number of patients attempting/completing suicide in career, per-

sonal experience with attempted/completed suicide, likelihood of choosing PAS for self, and likelihood of supporting a family member's choice for PAS. Table 3 displays predictor-level summary statistics for the logistic regression model. The set of predictor variables exerted a significant effect on clinicians' determinations of competence, Wald's $\chi^2(8) = 20.33$, $p = .02$, Cox and Snell $R^2 = .11$, Nagelkerke $R^2 = .16$. However, the overall model did not demonstrate an acceptable goodness-of-fit, $\chi^2(8) = 16.10$, $p = .04$. Clinicians who reported that someone in their personal life had attempted suicide were 2.84 times as likely to declare the patient competent than clinicians without such experience. Conversely, clinicians who reported that someone in their personal life had completed suicide were 0.31 times as likely to declare the patient competent than clinicians without such experience. Finally, for every one-point increase in the reported willingness to support a family member's choice of PAS, a clinician was 1.42 times as likely to declare the patient competent.

A one-way ANCOVA was again conducted to determine if clinician characteristics yielded a similar effect on clinicians' rating of competence. Personal experience with attempted suicide (yes, no) and personal experience with completed suicide (yes, no) were entered as between subject variables with clinician age, religiosity ratings, number of suicidal patients within the last year, number of patients attempting/completing suicide in career, likelihood of choosing PAS for self, and likelihood of supporting a family member's choice for PAS entered as covariates. Unexpectedly, a clinician's willingness to support a family member's choice for PAS yielded the only significant main effect on ratings of competence, $F(1, 169) = 3.96$, $p = .05$, $\eta_p^2 = .02$, $B = .26$. The more supportive of a family member's choice for PAS, the higher a clinician rated the patient's competence to be.

Exploratory analyses: Clinician perceptions of client characteristics. Given the empirical data supporting the utility of assessing perceived burdensomeness in suicidal patients, exploratory analyses sought to clarify clinicians' ratings of the importance of perceived burdensomeness compared to more traditional aspects of competence to request PAS determinations. Paired samples t tests revealed that a patient's perceived burdensomeness ($M = 3.7$, $SD = 1.7$) was rated less important to

Table 3
Logistic Regression Model Predicting Clinicians' Competence Decisions by Clinician Characteristics

Predictor	β	SE β	Wald (df)	<i>p</i>	OR	95% CI
Religiosity	.12	.11	1.25 (1)	.26	1.13	[.91, 1.40]
Clinician age	-.02	.02	.96 (1)	.33	.98	[.95, 1.02]
# of suicidal patients within last year	.03	.03	.85 (1)	.36	1.03	[.97, 1.08]
# of patients who attempted suicide in career	-.01	.01	.30 (1)	.59	.99	[.97, 1.02]
# of patients who completed suicide in career	.20	.19	1.12 (1)	.29	1.22	[.84, 1.76]
Personal experience with attempted suicide	1.04	.50	4.29 (1)	.04	2.84	[1.06, 7.63]
Personal experience with completed suicide	-1.17	.50	5.37 (1)	.02	.31	[.12, .84]
Likelihood of choosing PAS for self	.10	.15	.42 (1)	.52	1.11	[.82, 1.49]
Likelihood of supporting family member's PAS	.35	.16	4.94 (1)	.03	1.42	[1.04, 1.94]

Note. β = β weight; OR = odds ratio; CI = confidence interval; PAS = physician-assisted suicide. Ratings of religiosity and likelihood of choosing/support for PAS were scored on a 7-point scale in which greater scores represent greater religiosity/support for PAS. Personal experience with attempted/completed suicide coded: 0 = no one in personal life has attempted/completed suicide; 1 = someone in personal life has attempted/completed suicide.

competence determination than irreversibility of condition ($M = 6.3$, $SD = 1.5$) and cognitive ability ($M = 6.1$, $SD = 1.3$), $t(207) = -17.80$, $p < .001$, $d = -1.63$ and $t(207) = -17.87$, $p < .001$, $d = -1.61$, respectively. Perceived burdensome was also rated less important than physical ($M = 6.2$, $SD = 1.3$) or mental ($M = 5.7$, $SD = 1.4$) suffering, $t(207) = -18.64$, $p < .001$, $d = -1.64$ and $t(207) = -16.86$, $p < .001$, $d = -1.33$, respectively.

A binary logistic regression model predicting clinicians' ultimate decision on competence to request PAS was then conducted in order to explore the potential impact of importance ratings on competence determinations. Clinicians' importance ratings concerning irreversibility of condition, cognitive ability, physical/mental suffering, and perceived burdensomeness were entered into the model as predictor terms. Table 4 displays predictor-level summary statistics for the logistic regression model. The set of predictor variables did not significantly impact clinicians' competence to request PAS determinations, Wald $\chi^2(5) = 8.54$, $p = .13$, Cox and Snell $R^2 = .05$, Nagelkerke $R^2 = .07$, but demonstrated an acceptable goodness-of-fit, $\chi^2(8) = 5.51$, $p = .70$. Importance ratings regarding a patient's cognitive ability was the only predictor that explained a significant amount of variance in competence

determinations. For every one-point increase in the rated importance of cognitive ability, a clinician was 0.70 times as likely to declare the patient competent.

Discussion

Important Patient Characteristics

One of the major goals of this study was to identify patient characteristics that would be most important or influential in an evaluation of competency for PAS. In terms of patient characteristics, the largest effects were observed for experimental vignette condition (and my extrapolation those characteristics contained in each condition) and importance of MacCAT-T Appreciation scores. Regarding vignette condition, the patient with higher IQ and MacCAT-T scores, and lower BDI-II scores, was consistently rated as more competent. In other words, higher cognitive and lower depressive characteristics were associated with being found competent to request PAS. Further, the patient presented in the ambiguous condition was rated as more competent than the patient described in the incompetent condition, adding to this pattern. Additionally, the result of the ambiguous patient being rated as more competent than the incompetent patient suggests that clinicians were making the appropriate assumption of competence unless proven otherwise supported by forensic literature (Werth et al., 2000).

Of various patient factors surveyed, including the irreversibility of their condition, physical suffering, mental suffering, and perceived burdensomeness, patient cognitive ability was the only significant predictor of a clinician's competence decision. An intelligence score was provided in the vignette as a specific representation of cognitive ability. Interestingly, despite the importance placed on cognitive ability, perceived importance of IQ scores were not related to competence decisions. Instead, the perceived importance of the Appreciation and Reasoning components of the MacCAT-T were the only test scores that significantly predicted an ultimate decision and the perceived importance of the Reasoning score accounted for more variance than all other variables in terms of predicting ratings of competence. This may

Table 4
Logistic Regression Model Predicting Clinicians' Competence Decisions by Ratings of Perceived Importance of Patient Factors

Predictor	β	SE β	Wald (df)	<i>p</i>	OR	95% CI
Importance for competence determination						
Irreversibility of condition	.21	.14	2.47 (1)	.12	1.24	[.95, 1.61]
Cognitive ability	-.35	.16	4.89 (1)	.03	.70	[.52, .96]
Physical suffering	-.14	.17	.70 (1)	.40	.87	[.62, 1.21]
Mental suffering	.08	.17	.21 (1)	.64	1.08	[.77, 1.52]
Perceived burdensomeness	.12	.10	1.31 (1)	.25	1.12	[.92, 1.37]

Note. β = β weight; OR = odds ratio; CI = confidence interval. Ratings of importance were scored on a 7-point scale in which greater scores represent greater perceived importance to competence determinations.

suggest that clinicians would prefer use of the MacCAT-T in PAS evaluations. Appreciation refers to a patient's rational understanding of the disorder and treatment, including specific information regarding symptoms and possible outcomes of the diagnosis and treatment (Grisso & Appelbaum, 1998; Zapf & Roesch, 2009). Reasoning refers to the process through which the patient decides on a treatment. This includes the ability to consider relevant alternatives and weigh the consequences in a rational manner, ultimately arriving at a decision about what treatment would suit him or her best (Grisso & Appelbaum, 1998; Zapf & Roesch, 2009). The clinical decision making implication is that clinicians prefer a more functional representation of intact cognitive abilities than is afforded by an intelligence test. That is to say, clinicians placed more weight on cognitive ability as demonstrated by logical reasoning about their condition and treatment options as opposed to performing well on tasks such as assembling blocks and defining words. As such, from the standpoint of the clinician, an IQ test or screener may be unimportant in competence evaluation decisions for PAS. We are not explicitly advocating avoiding IQ tests in these evaluations, merely observing a subjective pattern in the data. Indeed, IQ tests may still prove beneficial in this assessment context, as clinician perceptions versus what is objectively helpful may not always be line.

Legislation (ORS 127.825 § 3.03) specifically cites a depressive disorder diagnosis as a potential cause of incompetence to request PAS. As such, the present study examined the perceived importance of either a patient's history or current symptoms of mental illness. Clinicians were provided with a BDI-II score for the patient in the vignette as one means of manipulating competence and in an effort to gauge the importance of depressive symptoms in a competence evaluation for PAS. Despite the emphasis placed on depressive disorders by the statute, the perceived importance of BDI-II scores was unrelated to competence decisions, complicating the importance of depressive symptoms in PAS competence evaluations. It is possible that scores on a self-report inventory were considered insufficient by clinicians and thus were relatively unimportant factors in their ultimate decision. Under typical circumstance, we would tend not to make much of a null finding in terms of policy or practice implications. However, the disconnect between the null influence of BDI-II scores and the fact that depression is specifically cited in the law is potentially troublesome. From a practice standpoint, clinicians may need to reflect further on how depressive symptoms could potentially complicate other PAS evaluation components such as decision or cognitive understanding. On the other hand, policy may need to place less emphasis on depression over other components of a PAS evaluation. In either case, more attention is needed concerning the assessment of, and policy emphasis on, depressive symptoms in the context of PAS evaluation.

Impact of Clinician's Personal Values Characteristics

Previous research suggests that experience with death is correlated with more positive attitudes toward PAS (DiPasquale & Gluck, 2001; Wilson et al., 2007). The present study operationalized experience with death exclusively in terms of either personal or professional experience with attempted or completed suicides. As hypothesized, clinicians who reported someone in their personal life had attempted suicide were nearly three times as likely

to declare the patient competent as those without such an experience. This was, by far, the largest observed effect of all personal characteristics. Conversely, those that reported someone in their personal life having *completed* suicide were less likely to declare the patient competent. Desire for PAS to be a legal option for personal use is another factor found to be positively correlated with favorable views of PAS (DiPasquale & Gluck, 2001; Fenn & Ganzini, 1999). In our study, clinicians were asked about both their likelihood of choosing PAS for themselves, as well as how likely they would be to support a family member's choice of PAS. The more willing clinicians were to support a family member, the more likely they were to declare the patient competent. Furthermore, of all the clinician variables included in the study, willingness to support a family member's choice of PAS was the only variable to yield a significant effect on how competent the patient was perceived to be.

Taken together, it is plausible that experience with suicide attempts and willingness to support a family member's decision to request PAS reflect an understanding of how someone could get to a point in their life where death is a favorable outcome, yielding empathy with that person's wishes. However, the suicide survivors in the sample (i.e., individuals having lost someone close to them by suicide) know firsthand the emotional and psychological distress experienced following a suicide (Andriessen, Beautrais, Grad, Brockmann, & Simkin, 2007; Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004; Grad, 1996) and may not want to burden others with that type of loss, thus rendering them less likely to recommend competence.

Exploratory analyses revealed an interesting disparity between how perceived burdensomeness is valued by perspective patients and clinicians. In the study, clinicians were asked to rate the importance of several factors in conducting a PAS competence evaluation: irreversibility of the condition, patient's physical suffering, patient's mental suffering, and patient's perceived burdensomeness. All factors were extracted from existing literature and represent the most prevalent reasons given as to why an individual would consider making a request for PAS (Wilson et al., 2007). Clinicians rated perceived burdensomeness as the least important factor in a determination of competence. However, perceived burdensomeness is an important component in one of the leading theories on suicide. According to the interpersonal theory of suicide, perceptions of burdensomeness can arise from serious or chronic physical illnesses (Van Orden et al., 2010). Van Orden and colleagues (2010) specify that perceived burdensomeness is best understood as an individual believing his or her existence poses an extreme negative weight (e.g., emotional, financial) on both close friends/family, as well as more distal persons (e.g., extended family). Perceived burdensomeness therefore encompasses self-perceptions of self-hatred and that one is a liability to others. In the PAS context, if an individual relies on others for care and financial support, and feels unable to provide any meaningful contribution (perhaps not unlike many individuals considering PAS), they may feel that they are a burden to those around them and their death may in fact be more valuable than their life (Van Orden et al., 2010). Perceived burdensomeness has been also been found to be a significant predictor of suicidal ideation in older adults, the primary demographic requesting PAS (Cukrowicz, Cheavens, Van Orden, Ragain, & Cook, 2011). Furthermore, according to the most recent publication from the Oregon Public Health Division,

loss of autonomy, which can lead to feelings of burdensomeness, has been the most frequently cited end of life concern by patients every year PAS has been available for use, with 93.5% of patients mentioning it in the past year (Oregon Public Health Division, 2012). When one considers the literature on the topic, the lack of importance attributed to perceived burdensomeness by clinicians in this study is potentially concerning, particularly given the results regarding the Reasoning score of the MacCAT-T. If a patient's primary motivation for requesting PAS is to not burden his or her family, it is possible that clinicians may view this as a poorly reasoned decision and perhaps as evidence that the patient is not fully competent.

Recommendations for Practice and Future Research

Clinicians in the present study would be legally permitted to perform a competence evaluation for PAS, as the state statute does not specify what experience is required of the individual conducting the assessment. That being said, psychologists have an ethical obligation to practice within their bounds of competence, per Standard 2.01 *Boundaries of Competence*, which includes the responsibility to "undertake relevant education, training, supervised experience, consultation, or study," should they wish to provide services in an area new to them (APA, 2010, p. 5). Thus, in order to perform an evaluation of competence to request PAS, clinicians should first and foremost consult forensic literature and familiarize themselves with definitions of competence and various prongs commonly assessed. Recommended resources for clinicians interested in developing knowledge on competence include, but are not limited to, *Forensic Mental Health Assessment: A Casebook* (Heilbrum, Marczyk, & DeMatteo, 2002), a chapter focusing on capacity assessment competence (Moye, Karel, & Armesto, 2007), and a recent review of competency restoration (Zapf & Roesch, 2009). Clinicians should also be familiar with the laws of their state in order to operate within the confines of the law and make use of the limited guidance it provides in terms of definitions relevant to a competence evaluation. Specific to PAS evaluations, clinicians should review the following statutes by state: Oregon (ODDA, 1995), Washington (Washington Death With Dignity Act, 2008), and Montana (Montana Death With Dignity Act, 2009).

Considering the discrepancy of how important perceived burdensomeness is for patients and clinicians, clinicians should educate themselves on theories of suicide, as well as characteristics of the terminally ill. Doing so may aid the clinician in evaluating the rationality of the patient's choice of PAS. Empirical and conceptual suicide literature that can help educate a clinician includes seminal texts on the interpersonal-psychological theory of suicide (Joiner, 2005; Van Orden et al., 2010) and various cognitive perspectives. The former theory specifically discusses PAS-relevant topics such as perceived burdensomeness and exposure to death/pain on contributing factors to suicide risk. Cognitive perspectives such as the cognitive vulnerability perspective (Alloy & Abramson, 1996) highlight important factors like negative schemas and hopelessness in understanding suicide risk. At least with respect suicide and psychology, annual conferences are also held by the American Association of Suicidology. Additionally, well-respected researchers and practitioners in the field of suicidology commonly hold workshops around the country for medical and

mental health professionals. Continuing education credits are often available during these trainings, which may provide added incentive for attendance. Trainings designed specifically to bolster PAS-related competence should include topics such as the interpersonal-psychological theory of suicide and cognitive perspectives on suicide, end-of-life issues, psychometrics of relevant psychological assessment instruments evaluating depression, suicide and competence, as well as review of pertinent legal standards.

The results of this study suggest that personal opinions and experiences have the potential to influence the outcome of the evaluation. Although it can be difficult to maintain objectivity given the controversial nature of PAS, it is the professional obligation of the clinician to do so. Prior to taking on a PAS evaluation, clinicians should reflect on their personal views about the practice and manage their attitudes, which may be accomplished through self-reflection, supervision, and consultation with professional colleagues (Cramer, Johnson, McLaughlin, Rausch, & Conroy, 2013). Ultimately, should the clinician feel their personal values "impair their objectivity, competence, or effectiveness in performing their functions as psychologists," they should decline or withdraw from the evaluation per Standard 3.06 *Conflict of Interest* of the APA Ethics Code (APA, 2010, p. 6).

Although, the authors of the MacCAT-T have stated that the instrument can be used without modification in competence evaluations for PAS (Werth et al., 2000), there is no empirical data to supporting this claim. Given the importance of the MacCAT-T Appreciation and Reasoning scores in the decisions made by clinicians, further examination of the utility of this instrument for PAS evaluations is warranted. This could be accomplished by creating a mock MacCAT-T protocol based on the most common characteristics of individuals that request PAS and varying the competence of the fictional patient. The protocol should be studied utilizing actual clinicians as participants to improve the validity of the results. Prior to being asked to make a competence decision based on the mock protocol, participants should receive some training on the MacCAT-T. In regard to training materials, research reporting psychometric properties of the instrument are available (see Appelbaum & Grisso, 1995; Grisso & Appelbaum, 1995; Grisso, Appelbaum, Mulvey, & Fletcher, 1995) as is the treatment manual (see Grisso & Appelbaum, 1998).

Educating oneself about PAS and the issues that surround it is one of the recommendations for clinicians considering participating in an evaluation of competence to make a request for PAS. In doing so, it would be helpful to have knowledge of patient characteristics that are most influential in their making a request; however, this information is only available in the abstract. That is, to the best of the authors' knowledge there are no available studies examining characteristics of actual PAS patients. Of particular importance might be characteristics that distinguish patients referred for a competence evaluation from those allowed to proceed unimpeded through the process. The ODDA requires the Oregon Health Division to record and maintain information from every individual that has requested PAS in Oregon since its implementation in 1998 (Oregon Health Division, 1999). The agency collects extensive data regarding patients and physicians involved in the process of PAS, such as patient demographics, end of life concerns, date of psychiatric consultation, date of prescription, date of ingestion, date of death, and enrollment in hospice care. In

addition to record reviews, prescribing physicians are interviewed either in person or via telephone to obtain data unavailable from reports and certificates. Specifically, information regarding the patient's insurance status, end-of-life care, end-of-life concerns, medications prescribed, and medical and functional status at the time of death are obtained from physician interviews (Oregon Health Division, 1999). Although the data is available for outside research if a data use agreement is approved by the Oregon Health Division, it is very difficult to obtain. Thus, it may fall to the Oregon Health Division to run analyses to identify patient characteristics that may be of particular importance when it comes to conducting a competence evaluation. Identification of any characteristics based on actual patient data would greatly advance existing research and improve competence assessments.

Given the forensic nature of the referral question in PAS evaluation, an interesting question regarding competence restoration among individuals requesting PAS arises. Considering the limited time available and that many individuals die before making it through the process, it is unclear whether restoration is a feasible goal for individuals deemed incompetent to request PAS. Furthermore, complications will likely arise with attempting to accomplish restoration in a primarily medical setting. Issues that readily come to mind are the identification of the best service providers for restoration as well as the competence evaluation postrestoration. While literature exists on restoration of competency to stand trial, both for individuals suffering from mental illness and cognitive impairments (e.g., Zapf & Roesch, 2011; Wall, Krupp, & Guilmette, 2003), it is unclear as to whether these techniques could be applied or modified to meet the needs of individuals classified as incompetent to request PAS. As PAS gains legal traction and is more widely used, empirical research regarding restoration will likely be necessary.

The primary limitation of this study was the limited information about the mock patient provided to participants. While this may have made competence decisions more difficult for some clinicians, the limited information was intended to minimize the time burden on participants. As discussed, we suggest future researchers provide clinicians with a complete interview, hopefully building upon the results of this initial experimental examination of clinician ratings of PAS competence. Another methodological concern may be the bias inherent in asking about self-reported ratings of importance of factors in arriving at a decision. Future research examining of objective data in the Oregon databases cited earlier could help improve upon this limitation. Representativeness of the sample is an issue requiring cautious attention. For instance, the 22.5% of respondents to the survey may not be fully reflective of the totality of psychologists in the 3 states where PAS is legal. It could be that those feeling particularly passionate about the issue (positive or negative) may have been more or less likely to participate. Further, data was not gathered from states in which PAS remains illegal. As existing empirical literature exists denoting geographic disparities on death-related attitudes (e.g., Halim & Stiles, 2001), comparisons to different parts of the country are not yet possible. Lastly, the present study failed to account for every potential situational or demographic characteristic of evaluators and patients. Future research would benefit from inclusion of additional variables such as clinician years of forensic assessment experience, source or nature of the specific referral question, and client race and gender.

References

- Achille, M. A., & Ogloff, J. R. P. (1997). When is a request for assisted suicide legitimate? Factors influencing public attitudes toward euthanasia. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement*, 29, 19–27. <http://dx.doi.org/10.1037/0008-400X.29.1.19>
- Alloy, L. B., & Abramson, L. Y. (1996). *The Temple–Wisconsin Cognitive Vulnerability to Depression Project (CVD) Project: Conceptual background, design, and methods*. Manuscript in preparation, Temple University, Philadelphia, PA.
- American Medical Association. (2000). *Code of medical ethics*. Retrieved October 28, 2011, from <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page?>
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- American Psychological Association (APA). (2010). *Ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics/code/index.aspx>
- Andriessen, K., Beautrais, A., Grad, O. T., Brockmann, E., & Simkin, S. (2007). Current understandings of suicide survivor issues: Research, practice, and plans. Report of the 1st International Suicide Postvention Seminar, September 8, 2006, Portoroz, Slovenia. *Crisis*, 28, 211–213. <http://dx.doi.org/10.1027/0227-5910.28.4.211>
- Appelbaum, P. S., & Grisso, T. (1995). The MacArthur Treatment Competence Study: I: Mental illness and competence to consent to treatment. *Law and Human Behavior*, 19, 105–126. <http://dx.doi.org/10.1007/BF01499321>
- Baxter v. Montana, 2009 MT 449 (Mont. 2009).
- Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory—2nd ed. (BDI-II) manual*. San Antonio, TX: The Psychological Corporation.
- Cicirelli, V. G. (1997). Relationship of psychosocial and background variables to older adults' end-of-life decisions. *Psychology and Aging*, 12, 72–83. <http://dx.doi.org/10.1037/0882-7974.12.1.72>
- Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences*. Mahwah, NJ: Lawrence Erlbaum, Inc.
- Committee on the Revision of the Specialty Guidelines for Forensic Psychology. (2011). *Specialty guidelines for forensic psychology*. Retrieved from www.ap-ls.org/aboutpsychlaw/SGFP_Final_Approved_2011.pdf
- Cramer, R. J., Johnson, S. M., McLaughlin, J., Rausch, E. M., & Conroy, M. A. (2013). Suicide risk assessment training for psychology doctoral programs: Core competencies and a framework for training. *Training and Education in Professional Psychology*, 7, 1–11. <http://dx.doi.org/10.1037/a0031836>
- Cukrowicz, K. C., Cheavens, J. S., Van Orden, K. A., Ragain, R. M., & Cook, R. L. (2011). Perceived burdensomeness and suicide ideation in older adults. *Psychology and Aging*, 26, 331–338. <http://dx.doi.org/10.1037/a0021836>
- DiPasquale, T., & Gluck, J. P. (2001). Psychologists, psychiatrists, and physician-assisted suicide: The relationship between underlying beliefs and professional behavior. *Professional Psychology: Research and Practice*, 32, 501–506.
- Farberman, R. K. (1997). Terminal illness and hastened death requests: The important role of the mental health professional. *Professional Psychology: Research and Practice*, 28, 544–547. <http://dx.doi.org/10.1037/0735-7028.28.6.544>
- Farrenkopf, T., & Bryan, J. (1999). Psychological consultation under Oregon's 1994 Death With Dignity Act: Ethics and procedures. *Professional Psychology: Research and Practice*, 30, 245–249. <http://dx.doi.org/10.1037/0735-7028.30.3.245>
- Fenn, D. S., & Ganzini, L. (1999). Attitudes of Oregon psychologists toward physician-assisted suicide and the Oregon Death With Dignity

- Act. *Professional Psychology: Research and Practice*, 30, 235–244. <http://dx.doi.org/10.1037/0735-7028.30.3.235>
- Ganzini, L., Leong, G. B., Fenn, D. S., Silva, J. A., & Weinstock, R. (2000). Evaluation of competence to consent to assisted suicide: Views of forensic psychiatrists. *The American Journal of Psychiatry*, 157, 595–600. <http://dx.doi.org/10.1176/appi.ajp.157.4.595>
- Grad, O. T. (1996). Suicide: How to survive as a survivor? *Crisis*, 17, 136–142. <http://dx.doi.org/10.1027/0227-5910.17.3.136b>
- Grisso, T., & Appelbaum, P. S. (1995). The MacArthur Treatment Competence Study: III: Abilities of patients to consent to psychiatric and medical treatments. *Law and Human Behavior*, 19, 149–174. <http://dx.doi.org/10.1007/BF01499323>
- Grisso, T., & Appelbaum, P. S. (1998). *MacArthur Competence Assessment Tool for Treatment (MacCAT-T)*. Sarasota, FL: Professional Resource Press.
- Grisso, T., Appelbaum, P. S., Mulvey, E. P., & Fletcher, K. (1995). The MacArthur Treatment Competence Study: II: Measures of abilities related to competence to consent to treatment. *Law and Human Behavior*, 19, 127–148. <http://dx.doi.org/10.1007/BF01499322>
- Halim, S., & Stiles, B. L. (2001). Differential support for police use of force, the death penalty, and perceived harshness of the courts: Effects of race, gender, and region. *Criminal Justice and Behavior*, 28, 3–23. <http://dx.doi.org/10.1177/0093854801028001001>
- Heilbrum, K., Marczyk, G. R., & DeMatteo, D. (2002). *Forensic mental health assessment: A casebook*. New York, NY: Oxford University Press.
- Johnson, S. M., Cramer, R. J., Conroy, M. A., & Gardner, B. O. (2014). The role of and challenges for psychologists in physician assisted suicide. *Death Studies*, 38, 582–588. <http://dx.doi.org/10.1080/07481187.2013.820228>
- Joiner, T. E. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.
- Lally, S. J. (2003). What tests are acceptable for use in forensic evaluations? A survey of experts. *Professional Psychology: Research and Practice*, 34, 491–498. <http://dx.doi.org/10.1037/0735-7028.34.5.491>
- Lloyd-Williams, M., & Payne, S. (2002). Nurse specialist assessment and management of palliative care patients who are depressed—A study of perceptions and attitudes. *Journal of Palliative Care*, 18, 270–274.
- Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer-Stephens, M. (2004). Complicated grief in survivors of suicide. *Crisis*, 25, 12–18. <http://dx.doi.org/10.1027/0227-5910.25.1.12>
- Montana Death With Dignity Act, Mt. Legal Code § 1818.01 (2009).
- Moye, J., Karel, M. J., & Armesto, J. C. (2007). Evaluating capacity to consent to treatment. In A. M. Goldstein (Ed.), *Forensic psychology: Emerging topics and expanding roles* (pp. 260–293). Hoboken, NJ: Wiley.
- Oregon Death With Dignity Act (ODDA), Or. Rev. Stat. §§ 127.800–127.995 (1995).
- Oregon Health Division. (1999). *Oregon's Death with Dignity Act: The first year's experience*. Retrieved from <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year1.pdf>
- Oregon Public Health Division. (2012). *Oregon's Death With Dignity Act: 2011*. Retrieved from <https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year14.pdf>
- Palmieri, G., Forghieri, M., Ferrari, S., Pingani, L., Coppola, P., Colombini, N., . . . Neimeyer, R. A. (2008). Suicide intervention skills in health professionals: A multidisciplinary comparison. *Archives of Suicide Research*, 12, 232–237. <http://dx.doi.org/10.1080/1381110802101047>
- Peng, C., Lee, K., & Ingersoll, G. M. (2002). An introduction to logistic regression analysis and reporting. *Journal of Educational Research*, 96, 3–14. <http://dx.doi.org/10.1080/00220670209598786>
- Sampson v. Alaska, 31 P. 3d 88 (Alaska 2001).
- Sears, S. R., & Stanton, A. L. (2001). Physician-assisted dying: Review of issues and roles for health psychologists. *Health Psychology*, 20, 302–310. <http://dx.doi.org/10.1037/0278-6133.20.4.302>
- Vacco v. Quill, 521 U.S. 793 (1997).
- Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E., Jr. (2010). The interpersonal theory of suicide. *Psychological Review*, 117, 575–600. <http://dx.doi.org/10.1037/a0018697>
- Wall, B. W., Krupp, B. H., & Guilmette, T. (2003). Restoration of competency to stand trial: A training program for persons with mental retardation. *Journal of the American Academy of Psychiatry and the Law*, 31, 189–201.
- Washington Death With Dignity Act, Wa. Rev. Code, chap. 70. §§ 245.010–70.245.904 (2008).
- Wechsler, D. (2008). *Wechsler Adult Intelligence Scale—Fourth Edition (WAIS-IV) Technical and interpretive manual*. San Antonio, TX: Pearson.
- Werth, J. L., Jr. (1999). When is a mental health professional competent to assess a person's decision to hasten death? *Ethics & Behavior*, 9, 141–157. http://dx.doi.org/10.1207/s15327019eb0902_5
- Werth, J. L., Jr., Benjamin, G. A., & Farenkopf, T. (2000). Requests for physician-assisted death: Guidelines for assessing mental capacity and impaired judgment. *Psychology, Public Policy, and Law*, 6, 348–372. <http://dx.doi.org/10.1037/1076-8971.6.2.348>
- 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. <http://dx.doi.org/10.1080/15228930802427130>
- 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. <http://dx.doi.org/10.1037/0278-6133.26.3.314>
- Zapf, P. A., & Roesch, R. (2009). *Evaluation of competence to stand trial*. New York, NY: Oxford University Press.
- Zapf, P. A., & Roesch, R. (2011). Future directions in the restoration of competency to stand trial. *Current Directions in Psychological Science*, 20, 43–47. <http://dx.doi.org/10.1177/0963721410396798>

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