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PERCEIVED PREPAREDNESS OF CALIFORNIA SOCIAL WORKERS TO DISCUSS PHYSICIAN ASSISTED DEATH

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PERCEIVED PREPAREDNESS OF CALIFORNIA SOCIAL WORKERS
TO DISCUSS PHYSICIAN ASSISTED DEATH

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Shanda Marie Brennan
Meliza Quinonez Kinney

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June 2017

Approved by:

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ABSTRACT

Effective June 9, 2016, many terminally ill patients residing in the State of California will now have the legal option of terminating their life because of protections offered under The California End of Life Options Act. Social workers whose population of care includes terminally ill patients will likely be engaging in conversations about end of life options, including physician assisted death, with their patients. Little research exists addressing what factors may influence social workers perceived preparedness to discuss physician assisted death with patients, yet the expectation that social workers be prepared to discuss all available end of life options with patients is present. The purpose of this quantitative study is to explore the influence of demographic characteristics and experience with terminal illness on California social workers perceived preparedness to discuss physician assisted death as an end of life option with terminally ill patients. Convenience sampling was utilized which included sixty-two Master of Social Work level or higher social workers who are employed in medical social work positions and are providing direct care for chronically and terminally ill patients. Participants completed a voluntary paper survey that gathered demographic information, experience with terminal illness and perceived preparedness to discuss physician assisted death with patients through Likert Scale measures. The findings showed a positive relationship between California social workers who perceived themselves as prepared to

discuss physician assisted death and the identification of their social work education as a source of their preparedness.

DEDICATION

To cancer, thank you for showing me how valuable every second of life is by threatening mine. You opened my eyes greater to the gift of life especially that of being called Mom by the pieces of my heart who walk around this earth, my sons, Aidan and Ethan. I will never love anyone greater than I love you both. Thank you, kiddos, for letting me grow beside you both.

To my husband, Lance, you're a brave man. Marrying me two days before the beginning of this MSW program was a risk, everything with me is a risk. I love you for loving me and supporting my desire for knowledge, for education, for advocacy, for flowers. Now that this chapter is ending, I say this to you, "Well, it's feeling like my life is finally mine...Without you I was broken, but I'd rather be broke down with you by my side."

Lastly, to those who rode along with me on the hilly road that winded through this program and cheered me on, I dedicate this to you. You're an eclectic bunch made up of my sister Dedra and her family, my Dad, my Grandma Marie, my best friend April, my research partner Meliza and my research advisor Dr. Lizano, and you share one trait, you're all incredibly special. You're special to me and will always be because you made the effort to show me that I was special to you during this journey. Thank you for your support, truly.

Shanda Marie Brennan

DEDICATION

To my boys! Gabriel Ian, my baby boy! I am so incredibly lucky to be your mommy. You are what keeps me going and my driving force in all that I do. I love you little man. Michael Ray, my old man and best friend. Thanks for all of your love, support, and patience. You believed in me when I didn't believe in myself. You make me a better me. Although our journey has been rough, we have made it through together. I love you always and forever! Kaydence, I love you sissy! My two little angles that I did not have the pleasure to meet, you will never be forgotten and will always be a part of my story.

Mama y Papa. Gracias por todo su amor y apoyo. Los quiero mucho! Also my brothers and sisters, especially Lisette, Aida and Adrian. I could have not made it through this journey without you all. Aida, I have you to thank for leading me into this profession and I can only hope to be as good of a social worker as you one day. Also, a thanks to my nephews. I love you all so very much!!!

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Meliza Quinonez Kinney

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CHAPTER ONE

INTRODUCTION

Problem Statement

It is commonly known that social workers are staple members of the collaborative team who works in caring for the biopsychosocial-spiritual needs of terminally ill patients. Hospice care social workers, palliative care social workers, medical social workers, geriatric social workers and clinical social workers are all likely to have interactions at some point with patients dealing with a terminal diagnosis and their families.

Effective June 9, 2016, many terminally ill California residents will have access to physician assisted death as an end of life option (Death with Dignity Acts, n.d.). This additionally means that effective June 9, 2016, a new element in end of life planning conversations between terminally ill patients and their social workers will be introduced, the legal option of physician assisted death. When Oregon enacted the ODDA into law in 1994, Oregon hospice clinicians, including social workers, were uncertain what their level of involvement would be with patients who were desiring physician assisted death to end their lives (Ganzini, Harvath, Jackson, Goy, Miller, & Delorit, 2002). Social workers in California may be wrestling with this same uncertainty now and with little support and substantial expectations. The NASW's position that social workers working with terminally ill patients "are expected to be familiar with the common and complex bioethical

and legal issues" that accompany end of life choices is very clear that social workers must be competent however, there is little mention of physician assisted dying in the "NASW Standards for Palliative & End of Life Care" guide (NASW, 2004). A study published in 2000 found that only 10% of responding social workers identified themselves as being "very familiar" with the NASW policy on "Client self-determination and end-of-life decision making" (NASW, 2004) which is the only NASW published guide on the subject.

With little discussion, the scope of which social workers encounter physician assisted aid in dying cases is prevalent. A 2002 study of the experiences of Oregon hospice nurses and social workers indicated that within two years of the enactment of the Oregon ODDA, 45% of responding hospice workers had directly worked with a client who has requested physician assisted aid in dying, 73% of cases had been reviewed with a hospice social worker and 61% of clients had been evaluated by a clinical social worker (Ganzini et al., 2002). Despite the apparent likelihood that California Social Workers will encounter a number of terminally ill clients equal to or greater than that of social workers in Oregon, there is a question as to their perceived level of preparedness. Seventy-eight percent of surveyed social workers in various health care settings reported feeling unprepared or feeling only slightly prepared to deal with ethical issues that may arise in end of life care situations (Csikai & Bass, 2001). Perceptions of preparedness may potentially be linked to levels of competence and as competence is a core value of the National Association of

Social Workers Code of Ethics (NASW, 1999), it is critical that California social workers feel prepared to engage in death with dignity discussions.

Purpose of the Study

The objective of this research study is to determine California Social Worker's perceived preparedness to discuss physician assisted death with their clients. The primary reason for this examination is due to recent changes in California State law with the "End of Life Option Act" and the prospect that California Social Workers may have to discuss this choice with some of their terminally ill clients. It was inferred that factors such as personal views/experiences with terminal illness, workforce training and education are further likely to increment California Social Worker's preparedness in discussing physician assisted death with their clients.

As other states have opted to allow this end of life option, along with the research that already exists about Social Workers from other states and their views on physician assisted death as it relates to their practice, it is significant to assess California Social Worker's current impression on their preparedness to discuss this subject matter. To be able to address the lack of information about the topic, specifically about California Social workers, research needs to be gathered in order to gain more insight as to which factors indeed influence current California Social Worker's preparedness to discuss physician assisted death with their clients. It is with a better understanding of California Social

Worker's preparedness in this realm that future measure can be possibly taken to better educate and equip them to talk about this end of life option with their clients.

The research method that will be utilized in this research study will be a cross-sectional quantitative design that draws from a non-probability convenience sample. Data will be drawn by using a self-report survey. The specific research design was elected because the study focuses on gathering data from two sizable groups of people at two specific different points in time. Lastly, due to the fact that the topic of the study may be viewed as sensitive and/or controversial, the use of a self-report survey would allow participants to sustain their anonymity.

Significance of the Project for Social Work Practice

The primary reason for the present research study results from recent policy changes that the "End of Life Option Act" encompasses and the possible impact that it will have on California Social Workers. The end of life option of physician assisted death to clients and the role of California Social Workers is unfamiliar and is a domain that has not yet been addressed. The lack of information that exists about the topic leaves Social Workers to wonder if this is indeed an area that they might need to become more familiar with especially when serving the terminally ill population.

The results of this study will potentially acknowledge how California Social Workers feel about the topic of physician assisted death and how certain factors such as personal views, experience with terminal illness, workforce training and education may influence their preparedness to inform and educate clients about this end of life option. The study results may uncover problems or limitations that exist when it comes to this profession and the matter of physician assisted death. Respectively, the findings may be of compelling importance to the organization of DaVita Dialysis, as this could help in the creation of potential educational material on the subject matter for its social workers. Additionally, there may also be a possibility of policy change within the organization for requiring and implementing its Social Workers to educate clients about this end of life option. Not only could this study be beneficial to the organization, but also to the California Medical Social Work field as a whole, as it could help to establish large scale educational courses to better prepare Social Workers to discuss physician assisted death with their terminally ill clients.

The study aims to help inform the “Implementation Stage” of the Generalist Intervention Model. It has been numerous times that the “End of Life Option Act” has been brought into effect and that physician assisted death is now being carried out within California. The “Implementation Stage” of this model allows for monitoring and revisions of plans or goals when it comes to both micro and macro social work practice (Andrews University, n.d.). The influence that new decree has on Social Work Practice in California is inevitable. The role of

the social worker will indeed change and this might lead to the implementation of new regulations and policies within organizations. Therefore, this research study is the best suited to address the “Implementation Stage” of the generalist intervention model.

Research will be conducted to identify: What is the relationship between demographic/personal characteristics, experience with a terminal illness and educational/professional training and a California social worker's perceived preparedness to discuss physician assisted dying with their clients?

CHAPTER TWO

LITERATURE REVIEW

Introduction

In this section, historical literature and findings that discuss physician assisted death and contributing factors which influence an individual's perceived preparedness to discuss this as an end of life care option in their field of practice will be discussed. While limited research has been conducted in this specific area, literature and findings which discuss social workers education, professional training, familiarity with end of life practices and personal demographic characteristics in relation to their perceptions of preparedness on physician assisted death are reviewed. Due to the strong influence that belonging to "membership groups" has on a social worker's personal identity, literature will be viewed through the lens of Social Identity Theory which suggests that a social worker's belonging in certain identity groups will influence their perceived preparedness to discuss physician assisted death with their clients. In conclusion, this literature review will analyze how demographic characteristics, education and professional training influence competence and preparedness in association with end of life care options, specifically physician assisted death.

California Social Workers and End of Life Option Act

Effective June 9, 2016, many terminally ill patients in the State of California were given the legal option of seeking medical aid in dying medications

which would hasten their death should they qualify under the comprehensive guidelines set forth by the legislature under the “End of Life Option Act” (Death with Dignity Acts, n.d.). For the purpose of this review, the terms “physician assisted death”, “euthanasia”, “physician assisted suicide”, “assisted suicide” and “medical aid in dying” will all refer the same act of a patient/client seeking to end their life through the medical prescribing of a lethal dose of medication. While California physicians are tasked with evaluating and ultimately approving a patient’s requests for aid in dying medications (Death with Dignity Acts, n.d.), social workers in the state will likely engage in multiple aspects of this end of life care option with their clients, if they haven’t already done so, despite physician assisted death being illegal in California.

Social Worker Exposure to Medical Aid in Dying

A great number of social workers across the country, in multiple scopes of practice have indicated that regardless of physician assisted death’s legality, many have discussed, received requests for assessed clients seeking medical aid in dying; while a small number of social workers have acknowledged being an active participant in assisting a client with their medically aided death. According to Ganzini et al (2002), 45% of hospice care nurses and social workers reported having cared for at least one patient who requested a physician’s prescription for aid in dying medications (Ganzini, et al., 2002). Prior to the legalization of physician assisted death in Washington, a study by Wash, Ogden and Young

(2003), surveyed social workers in the state on their attitudes towards physician assisted suicide (AS) and voluntary euthanasia (VE); Their findings indicated that 21.4% of respondents had been consulted about VE and 22.9% about AS. Nineteen social workers noted they had assisted in the hastening of a patient's death by VE and 5 by AS, prior to the Washington decriminalization of these acts. These findings are echoed in a 1997 study by Pomeroy et al., in which 71 social workers were surveyed and of those only 17% responded that they had zero patients who had ever discussed suicide with them while 57% of them reported having one or more clients discuss euthanasia with them in the past. Ellen Csikai (1999) resulted in almost one fourth of the 122 hospital social workers surveyed has been asked about physician assisted death by a client at some point during their social work career.

Social workers, in many scopes of practice, have encountered clients who discuss the end of life option of physician assisted death with them, regardless of legality in their state of practice. California social workers will be experiencing these discussions in a greater quantity now that the law has been enacted.

Perceived Preparedness, Competence and Training

End of life care requires an expansive skill set which includes both academic and practical knowledge. Training and perceived competency may influence a social workers perceived preparedness to discuss physician assisted death, however, little research exists which examines social worker's perceptions

of preparedness to specifically discuss medically assisted death as an end of life care option exists. Despite this, related research has been conducted analyzing the education and training of social workers regarding end of life care options (Csikai & Raymer, 2005), social workers' perceived capability of assisting elders with end of life care decisions (Kane, Hamlin, Hawkins, 2005) as well as health care social workers views of ethical issues, practice, a policy in end of life care (Csikai & Bass, 2000) which all indicate that social workers indicate some perceived preparedness, but many not being as prepared as they need to be or would like to be in dealing with end of life care issues (Christ & Sormanti, 1999).

The National Association of Social Workers (NASW) has disseminated "issue statements" regarding medically aided death and has additionally created the "NASW Standards of Social Work Practice in Palliative and End of Life Care" (2003) in an effort to educate social workers faced with assisting clients with end of life decisions. In a 2000 study on health care social workers, 26% of the social workers who participated were unfamiliar with the NASW policy statement (1996) and only 10% were very familiar with the statement (Csikai & Bass, 2000). Additionally, among respondents who spent the majority of their practice dealing with end of life decisions (76%-100% of practice time), over 65% reported being just "moderately familiar" with the policy statement (Csikai & Bass, 2000).

Social worker's initial exposure to training in end of life care typically begins during their academic experience and educational curriculum when

obtaining their BSW or MSW degrees and continues through optional and required continuing education courses. Csikai and Bass (2001) surveyed 63 social workers belonging to the NASW-TX chapter. Survey respondents were questioned regarding the amount and scope of education and training that they had received addressing issues involving end of life health care, including assisted suicide. Only 18% of those surveyed reported receiving social work program education and 21% reported receiving continuing education curriculum on the principles of biomedical ethics (Csikai & Bass, 2000), the branch of applied ethics which studies issues linking how medical decisions, including medically aided death, influence both individuals and society (Adelaide Center for Bioethics and Culture, 2013). In an alternate survey respondents indicated that receiving biomedical ethical training in social work programs and continuing education is needed in “a large amount”, yet they received only a “moderate amount” of education on the topic (Csikai & Raymer, 2005). Respondents additionally reported that nearly 75% of them received education in their social work program as well as in continuing education courses on emerging ethical issues in health care (Csikai & Bass, 2000), which would likely include physician assisted death, especially in California due its recent legalization. While research indicates that education on hot topics such as medically aided death is being covered, the biomedical ethical component is less likely to be taught.

Content of educational components is one element of training for preparedness by social workers and their perceived level of preparedness to

handle end of life issues, based on educational curriculum evaluated in a research study completed by Csikai and Raymer (2005), which surveyed 394 social workers, nationwide who worked in a variety of settings which are commonly exposed to end of life issues. The sampling frame consisted of nephrology social workers, pediatric oncology social workers, hospice social workers, home health social workers, oncology social workers and health care social workers in leadership positions. This study yielded results that acknowledged multiple disparities between social worker's perceptions of competence needed in various skills related to end of life care and the amount of end of life care educational content that they received in both continuing education courses and social work degree programs (Csikai & Raymer, 2005). A Likert scale was administered ranging from 1 (not at all) to 5 (extremely important). In every area questioned, including end of life decision making, respondents indicated the perceived level of content needed in social work educational programs and continuing education was greater than the level of content the respondents received in their social work programs and continuing education (Csikai & Raymer, 2005).

Research findings have not yielded congruent results as to social workers perceived preparedness to assist with end of life care options. A systematic sample of Florida licensed clinical social workers was completed on their perceived preparedness in assisting elders with end of life care options. Respondents perceived themselves as being prepared and capable of

providing support during this time in a client's life (Kane, Hamlin & Hawkins, 2005). Respondents also rated themselves high in overall knowledge of resources available to elders. These responses suggest a relationship between knowledge of resources and perceived preparedness to assist elders with end of life care options. (Kane et al., 2005).

In short, social workers possess perceptions of preparedness that may influence their effective delivery of end of life care services to the clients and their families. Education is viewed as an integral and necessary component of a social worker's professional development, both prior to earning their BSW or MSW degrees as well as post degree and post licensure. While both social work program curriculums and continuing education courses briefly address areas that are relevant to physician assisted death, respondents indicated that they would benefit from increased educational curriculum in specific areas of practice that pertain to end of life options, including biomedical ethics.

Demographic Influences

The influence of personal demographic characteristics in relation to perceived preparedness to discuss end of life options with clients was not located in any established researched studies, peer reviewed article or journals. Social workers in the research completed exhibited homogenous characteristics in gender and race, with all cited research noting a significantly higher proportion of female respondents to males and white/Caucasian respondents as compared to

other racial categories, although this is representative of the social work professional demographic with nearly 82% of social workers reported as female (NASW, 2006d) and 86% reported as white/Caucasian (NASW, 20006b). Age and religious identification are both predictive identifiers in multiple research studies of support for physician assisted suicide in physicians, nurses and social workers (Bachman et al., 1996; Csikai, 2000; Ogden & Young, 2003 & Portenoy et al., 1997). These findings demonstrate the need for further research that is to be completed by this study as to demographic characteristics and their potential influence on California social workers feeling of preparedness to discuss physician assisted death with their clients.

Theories Guiding Conceptualization

Several socio-psychological theories address individuals in relationship to their beliefs and perceptions and of these Social Identity Theory is the framework utilized to direct this study. Social Identity Theory suggests that an individual's personal identity is formed through their membership in various identity groups, both given and chosen. Social Identity Theory acknowledges that most social categories can be viewed as membership groups such as religious identity, gender, age and organized memberships (Tajfel & Turner, 1986). As an example, membership in the NASW constitutes an identity group of which one belongs to. Social Identity Theory asserts that people's membership in these groups ultimately shapes their self-image and therefore influences how they view

and interact with members of their own identity groups (in-group) as well as members of other groups (out group) (Tajfel & Turner, 1986).

Social worker's personal experiences, demographic characteristics and educational/training experience are identity groups and social workers perceptions of preparedness in discussing physician assisted death with clients will be influenced by the self-identity created through their membership in various identity groups. This exploratory study aims to examine the relationship between the following California social worker's identity groups: age, gender, educational/training experience, religious identity, religiosity, personal or professional experience with a terminal illness diagnosis and their perceived preparedness to discuss physician assisted death with their clients.

It is critical to understand where social workers gain their level of preparedness to discuss physician assisted death. Organizations who employ social workers that work with the terminally ill could better focus limited resources on the development of appropriate training and identification of social workers working with terminally ill patients who may need additional support in discussing physician assisted death based on their characteristics or experiences.

Social Identity Theory would suggest that social workers who desire to work with terminally ill clients share that as an identity group. Of this group, some will share the identity group of those who feel prepared and others of those who do not feel prepared to discuss physician assisted death. Further broken down, these social workers also share additional identity groups such as age,

gender, race or ethnicity, training, education and history of experience with a terminal illness. The identification of specific identity group memberships that contribute to the increase and/or decrease of a social workers perceived preparedness to discuss physician assisted death with clients would assist in understanding the needs of social workers who work with this population thereby allowing for resources to be developed and disseminated to the right audience, on this sensitive and controversial topic.

Summary

The information studied in the above literature and findings suggests that social workers feel some level of perceived preparedness to discuss physician assisted death as an end of life care option, however, many of them are not as prepared as they would like to be. Social Worker's indicate that education, training and the familiarity of professional literature on physician assisted death all impact their perceived level of preparedness surrounding physician assisted death and other end of life care options. Additionally, the literature reviewed indicated that personal demographic characteristics do play a role in physician, nurse and social worker's support of physician assisted death as an end of life option, however more conclusive data is needed to determine if there is any relationship between social worker's demographics and perceived preparedness to discuss physician assisted death with their clients.

CHAPTER THREE

METHODS

Introduction

This study is aimed at gaining insights into the issues of social worker perceived preparedness to discuss physician assisted death and provide a basis of data for further investigation by future researchers. This chapter explains how the study was executed. This segment will examine the sections of study design, sampling, data collection and instruments, procedures, protection of human subjects, and data analysis.

Study Design

The purpose of this study is to address the relationship between demographic and personal characteristics in association to social workers perceived levels of preparedness to discuss physician assisted death with patients. Due to the preliminary stage of research into this problem, our research study will be exploratory in nature as research in the area of social workers and physician assisted death is extremely limited, especially in California due to the newness of the California End of Life Option Act's implementation. An exploratory methodology will allow for flexible and dynamic collection and analysis of this critical yet limitedly researched topic. Through this method we aim to build on the existing research and increase the level of understanding of social workers relationship with physician assisted death.

This study is a quantitative analysis of data that has been collected from a cross-sectional convenience sampling of California nephrology social workers. Participants were asked to complete a voluntary survey which aimed to gather specific descriptive statistics including demographic information, personal and professional characteristics and direct experience with a terminal illness diagnosis (See Appendix A). This survey instrument additionally gathered subject's level of agreement with specific statements that were intended to measure their level of perceived preparedness to discuss physician assisted death with clients.

A limitation of utilizing an exploratory, quantitative research methodology is that definitive conclusions will not be able to be drawn from the data due to the limited level of statistical strength. This research is not intended on providing conclusive evidence, but is intended to expand the understanding of influences on perceived preparedness regarding physician assisted death.

This study seeks to answer the question: What is the relationship between demographic/personal characteristics, experience with a terminal illness and educational/professional training and a California social worker's perceived preparedness to discuss physician assisted dying with their clients?

Sampling

Sixty-two California medical social workers, whose population of care are primarily patients who have been diagnosed with end stage renal disease or

chronic kidney disease, met on October 19, 2016 for a semi-annual divisional social worker meeting. Requirements to participate as a member of our sample included being a medical social worker, in attendance at the divisional social worker meeting, who provide direct care to patients suffering from end stage renal disease. Each social worker in attendance at this divisional meeting, who met the participation qualifications, was presented with the voluntary option to complete the survey. Survey subjects all provide direct client care to patients who are suffering from chronic illness which often lead to a terminal diagnosis, making many of them eligible for physician assisted death under the California End of Life Options Act. Due to the fact that these medical social workers often provide patients with resource linkage to hospice and other end of life care options, they will likely face client requests for informational resources regarding the California End of Life Option Act.

Data Collection and Instruments

Quantitative data was collected through voluntary self-reported, anonymous, survey completion on October 19, 2016 at the semi-annual divisional social worker meeting (See Appendix A). The distributed survey instrument was created by the researchers to gather data on demographic information, personal and professional characteristics, experience with a terminal illness and included a standard 7 indicator Likert scale which aimed to measured

overall perceived preparedness in relation to physician assisted death in California and the California End of Life Option Act.

The Likert scale utilized to measure perceived preparedness asked respondents to indicate their level of agreement with 12 unique questions which measured multiple aspects that contribute to or indicate an overall level of perception of preparedness related to physician assisted death and The California End of Life Option Act. Available responses included a total of 7 options which were assigned values of 1-7 including “Strongly Disagree” (1), “Neither Agree Nor Disagree” (4) and “Strongly Agree” (7). Questions were asked from both negative and positive perspectives which will result in the reverse coding of negatively posed questions, during data input and analysis.

Within this study the dependent variable studied was California Social Workers perceived preparedness to discuss physician assisted death with their clients. Independent variables included gender, age, race/ethnicity, education level, years in social work field, years in current position, religious affiliation, religiosity, professional interaction with a terminal patient and personal experience with a terminal illness.

Our survey instrument was pretested through expert evaluation. A social work topic expert who has extensive knowledge and expertise regarding the role of nephrology social workers in end of life care matters reviewed the survey instrument along with a survey methodologist possessing knowledge and expertise in data collection methodologies. It was concluded by both expert

evaluations that the survey instrument questions would allow for the collection of accurate descriptive data as well as data measuring California social workers perceived preparedness to discuss physician assisted death with their patients.

Procedures

Data was gathered on October 19, 2016 at the semi-annual divisional social worker meeting for San Bernardino County and Riverside County nephrology social workers. This meeting began at 9:00 a.m. and concluded at 3:30 p.m. Prior to the meeting, a table was set up at the rear of the conference room which contained a box marked for completed survey deposit and folders each containing a survey and informed consent. At the start of the meeting both researchers spoke to the group and offered them a brief overview of who we were, information on the study we were conducting, expressed the voluntary, anonymous and confidential nature of participation, explained eligibility for participation requirements and where to deposit the surveys and informed consents upon completion. Surveys and writing instruments were passed out and participants were told that when they returned their completed survey, they would receive a raffle entry to a drawing for one of four \$25 gift cards. Participants were told that survey submission would conclude at the end of the divisional meeting at 4:00 p.m. at which time the drawing would be held.

At 3:30 p.m. an announcement was made by the social work administrator that the surveys needed to be deposited and that the raffle would be taking place

in 5 minutes. After all of the surveys were deposited, both researchers thanked the entire group for their time and participation and expressed that if they had any questions or needed any debriefing resources we would be at the back of the room to assist them. Four raffle tickets were drawn by an impartial party who was not a study participant or researcher and gift cards were given to the 4 unique winners.

At the conclusion of the raffle, participants approached us with positive feedback regarding the study, the ease of use of the survey and their interest in hearing of the study results once published. There were no requests from participants for additional debriefing resources.

Protection of Human Subjects

Confidentiality and anonymity were of great priority in this data collection in order to establish the protection of the human subjects within this study. Each “perceived preparedness on physician assisted death study” folder included both a survey and an informed consent (See Appendix B) that defined the purpose of the study. This document insured anonymity as the questionnaire encompassed no identifiable information in regards to the individual or to the organization in which they currently are employed by. Participants were also assured that questionnaires would be destroyed no more than six months after data collections by the investigators. To further protect study participant’s identities, the informed consent did not require a possible legible signature, but instead

utilized an “X” to demarcate the respondent's acceptance to participate in the study. Additionally, it was presented that participation in this study was strictly voluntary and that participants could withdraw their questionnaire at any time without any repercussions. Upon completion of the questionnaire, participants located the designated drop off area, where they deposited their completed surveys into a drop box labeled “Please Deposit Surveys Here”.

The completed surveys were kept in a lock box located at one of the investigator's place of residence. The data file was saved on a USB drive that was password protected. The investigators were the only individuals with access to the data file. The password for the data file was also only be available to the investigators.

Data Analysis

The analysis of this data was quantitative in nature. The normality of the data was examined (e.g. skew and kurtosis) and several analyses were carried out. A multivariate analysis of independent variables, with varying levels of measurement, including gender (nominal), age (ratio), race/ethnicity (nominal), education level (nominal), years in social work field (ratio), years in current position (ratio), religious affiliation (nominal), religiosity (nominal), professional interaction with a terminal patient (nominal) and personal experience with a terminal illness (nominal) and their relationship with the dependent variable of

California Social Workers perceived preparedness to discuss physician assisted death with their clients was reviewed.

Twelve unique survey questions, measuring perceived preparedness to discuss physician assisted death, were used to develop a perceived preparedness to discuss physician assisted death scale. Selected questions were reversed coded in order for greater preparedness questions to be congruent throughout the study.

A bi-variate correlation analysis was employed in an attempt to identify which of the independent variables could be used to predict California social workers preparedness to discuss physician assisted death with clients, thereby answering the questions posed by our research study. The correlations between the descriptive statistics, demographics and characteristics, and the dependent variable, perceived preparedness, were identified and analyzed. All relationships were either correlational or descriptive in nature.

Summary

Chapter 3 outlined the study's design and procedures for data collection. Additionally, it shared what analysis would be completed of the data that was comprised in the questionnaire. It also granted for the protection of human subjects and the measures that were taken in order to sustain participant's complete anonymity and confidentiality.

CHAPTER FOUR

RESULTS

Introduction

The purpose of this chapter is to outline the results of the statistical analysis conducted. This chapter will include a detailed report of the sample, descriptive statistics and the results of the inferential statistics analysis conducted. The initial section will provide a summary of the descriptive statistics of the study sample obtained by conducting a frequency distribution which includes Race/ethnicity, level of education, religious identification and religiosity. Additionally, a summary of the mean and standard deviations of age, social work experience and years in current position will be outlined. The final sections will provide a summary of the significant findings that were yielded from a correlation analysis of the central study variables as noted in Table 2.

Presentation of Findings

Descriptive Statistics

The mean age of survey participants, as presented in Table 1, was 38 years ($SD=10.35$). Over three quarters of the survey participants identified as female ($n=56$, 90.30%) and 6 (9.70%) identified as male. Survey participants reported a mean of 115.16 months ($SD=86.35$) or 9.633 ($SD=7.20$) years of experience as a social worker. Survey participants reported being in their current

position for a mean of 55.85 months (SD=64.70) or 4.65 years (SD=5.39). Twenty-three (37.10%) of the participants identified as Non-Hispanic White, 5 (8.06%) participants identified as Black or African American, 4 (6.45%) participants identified as Asian American/Pacific Islander, 26 (41.94%) of participants identified as Hispanic/Latino and 2 (3.23%) of participants identified as other. More than three-quarters of the survey participants reported their highest level of education as MSW (n=62, 88.71%) and 7 (11.29%) selected “other”. Two (3.23%) survey participants reported their religious identification as Protestantism, 14 (22.58%) survey participants reported their religious identification as Catholicism, 24 (38.71%) survey participants reported their religious identification as Christianity, 3 (4.84%) survey participants reported their religious identification as Judaism, 3 (4.84%) survey participants reported their religious identification as Islam, 4 (6.45%) survey participants reported their religious identification as non-denominational, 7 (11.29%) survey participants reported their religious identification as “no religion” and 4 (6.45%) survey participants reported their religious identification as “other”. Survey participant’s religiosity was measured through reported frequency of attendance at religious services other than weddings and funerals. Five (8.06%) survey participants reported they attend religious services more than once a week, 11 (17.74%) survey responded they attend religious services once a week, 10 (16.13%) survey participants reported they attend religious services a few times a month,

14 (22.58%) survey participants responded they attend religious services a few times a year, 14 (22.58%) survey participants responded they attend religious services “seldom” and 7 (11.29%) survey participants responded they attend religious services “never”.

| Table 1. Demographic Characteristics of Study Sample | | | | |
|--|----|--------|--------|-------|
| | N | % | M | S.D. |
| Age | | | 38.00 | 10.35 |
| Sex | | | | |
| Female | 56 | 90.30% | | |
| Male | 6 | 9.70% | | |
| Social Work Experience | | | 115.16 | 86.35 |
| Years in Current Position | | | 55.85 | 64.70 |
| Race/Ethnicity | | | | |
| Non-Hispanic white | 23 | 37.10% | | |
| Black or African American | 5 | 8.06% | | |
| Asian American /Pacific Islander | 4 | 6.45% | | |
| Hispanic/Latino | 26 | 41.94% | | |
| Other | 2 | 3.23% | | |
| Level of Education | | | | |
| MSW | 55 | 88.71% | | |
| Other | 7 | 11.29% | | |
| Religious Identification | | | | |
| Protestantism | 2 | 3.23% | | |
| Catholicism | 14 | 22.58% | | |
| Christianity | 24 | 38.71% | | |
| Judaism | 3 | 4.84% | | |
| Islam | 3 | 4.84% | | |
| Non-denominational | 4 | 6.45% | | |
| No religion | 7 | 11.29% | | |
| Other | 4 | 6.45% | | |
| Religiosity | | | | |

| | | |
|-----------------------|----|--------|
| More Than Once a Week | 5 | 8.06% |
| Once a Week | 11 | 17.74% |
| A Few Times a Month | 10 | 16.13% |
| A Few Times a Year | 14 | 22.58% |
| Seldom | 14 | 22.58% |
| Never | 7 | 11.29% |

Note: One respondent did not indicate religious identification, one respondent did not indicate religiosity and two respondents did not indicate race/ethnicity.

Inferential Statistics Analysis

Analysis of inferential statistics was completed utilizing SPSS software version 24. Correlation analysis was conducted of the central study variables presented in table 2 (See Appendix C). Discussed here are only the significant relationships that were found.

Inter-item Correlation between Demographic Characteristics and Survey Items

Age was significantly correlated with Years Social Work Experience ($r = .73, p \leq .01$), Years in Current Job position ($r = .55, p \leq .01$), Survey Item 1, social worker's education has prepared them to discuss physician assisted death ($r = .28, p \leq .05$), Survey Item 4, California End of Life option Act information being readily available ($r = .39, p \leq .01$), Survey Item 5, feeling prepared to provide information on physician assisted death if asked ($r = .34, p \leq .05$), Survey Item 10, having spent time familiarizing self with The California End of Life Option Act ($r = .49, p \leq .01$) and Survey Item 12, unsure of the NASW's best practices regarding physician assisted death. ($r = .32, p \leq .05$). Race/ethnicity was

significantly correlated with Religiosity ($r = .29$, $p \leq .01$) and Survey Item 12, unsure of the NASW's best practices regarding physician assisted death ($r = .27$, $p \leq .05$) and was negatively associated with Survey Item 8, uncertainty on how they would feel if a client requested resources on physician assisted death ($r = -.29$, $p \leq .05$). Highest Level of Education Completed was positively correlated to religiosity ($r = .32$, $p \leq .01$), Professional Experience with Terminal Illness ($r = .36$, $p \leq .05$) and Survey Item 3, not feeling that education and/or training has prepared them to discuss physician assisted death with clients ($r = .30$, $p \leq .01$).

Personal Characteristics and Experiences Relationship to Survey Items

Having personal experience with individual(s) that were terminally ill was significantly correlated with Survey Item 7, believing physician assisted death to be a valid end of life option for some patients in California ($r = .31$, $p \leq .05$) and was negatively associated with Survey Item 9, feeling confident knowing they are able to link patients requesting information on physician assisted death with resources ($r = -.30$, $p \leq .05$), Survey Item 10, having spent time familiarizing self with the California End of Life option Act ($r = -.35$, $p \leq .05$) and Survey Item 11, needing more education on the California End of Life Option Act in order to feel comfortable discussing with clients ($r = -.29$, $p \leq .05$).

Professional Characteristics and Experiences Relationship to Survey Items

Having professional experience with individual(s) that were terminally ill was significantly correlated with survey participants education level ($r = .36$, $p \leq$

.01). Additionally, having professional experience with terminally ill individual(s) was negatively associated with Survey Item 3, not feeling that education and/or training has prepared them to discuss physician assisted death with clients ($r = -.26, p \leq .05$).

Perceived Preparedness

A 12 item perceived preparedness survey was administered to survey participants. Significant relationships were found between some individual survey items. Survey Item 1, social worker's education has prepared them to discuss physician assisted death was significantly correlated with Survey item 2, feeling prepared to discuss physician assisted death with their clients and caregivers ($r = .59, p \leq 0.01$), Survey Item 3, not feeling that education and/or training has prepared them to discuss physician assisted death with clients ($r = .46, p \leq 0.01$), Survey item 5, feeling prepared to provide information on physician assisted death if asked ($r = .43, p \leq 0.01$) and Survey Item 10, having spent time familiarizing self with The California End of Life Option Act ($r = .36, p \leq 0.01$). Survey Item 2, all in all in believing that they were prepared to discuss physician assisted death with their clients and caregivers, was positively correlated with Survey Item 3, not feeling that education and/or training has prepared them to discuss physician assisted death with clients ($r = .38, p \leq 0.01$), Survey Item 4, California End of Life option Act information being readily available ($r = .40, p \leq 0.01$), Survey Item 5, feeling prepared to provide information on physician

assisted death if asked ($r = .71, p \leq 0.01$), Survey Item 9, feeling confident knowing they are able to link patients requesting information on physician assisted death with resources ($r = .40, p \leq .01$), Survey Item 10, having spent time familiarizing self with The California End of Life Option Act ($r = .44, p \leq .01$), Survey Item 11, needing more education on the California End of Life Option Act in order to feel comfortable discussing with clients ($r = .27, p \leq .05$), and lastly Survey Item 12, unsure of the NASW's best practices regarding physician assisted death ($r = .31, p \leq .05$). Survey Item 3, not feeling that education and/or training has prepared them to discuss physician assisted death with clients was significantly correlated with four other survey items, Survey Item 5, feeling prepared to provide information on physician assisted death if asked ($r = .35, p \leq .01$), Survey Item 10, having spent time familiarizing self with The California End of Life Option Act ($r = .26, p \leq .05$), Survey Item 11, needing more education on the California End of Life Option Act in order to feel comfortable discussing with clients ($r = .29, p \leq .05$) and Survey Item 12, unsure of the NASW's best practices regarding physician assisted death ($r = .31, p \leq .05$). Survey Item 4, California End of Life option Act information being readily available was positively correlated with Survey Item 5, feeling prepared to provide information on physician assisted death if asked ($r = .49, p \leq .01$), Survey Item 10, having spent time familiarizing self with The California End of Life Option Act ($r = .61, p \leq .01$) and Survey Item 11, needing more education on the

California End of Life Option Act in order to feel comfortable discussing with clients ($r = .35, p \leq .01$). Survey Item 5, feeling prepared to provide information on physician assisted death if asked was significantly correlated with Survey Item 9, feeling confident knowing they are able to link patients requesting information on physician assisted death with resources ($r = .50, p \leq .01$), Survey Item 10, having spent time familiarizing self with The California End of Life Option Act ($r = .53, p \leq .01$), Survey Item 11, needing more education on the California End of Life Option Act in order to feel comfortable discussing with clients ($r = .32, p \leq .05$) and Survey Item 12, unsure of the NASW's best practices regarding physician assisted death ($r = .36, p \leq .01$). Survey Item 6, unfamiliarity with the NASW's position on physician assisted death was not significantly correlated with any other Survey Items. Survey Item 7, believing physician assisted death to be a valid end of life option for some patients in California was positively correlated with Survey Item 8, uncertainty of how they will feel if a client requests resources on physician assisted death ($r = .25, p \leq .05$). Survey Item 8, uncertainty of how they will feel if a client requests resources on physician assisted death was significantly correlated with Survey Item 11, needing more education on the California End of Life Option Act in order to feel comfortable discussing with clients ($r = .31, p \leq .05$). Survey Item 9, feeling confident knowing they are able to link patients requesting information on physician assisted death with resources was positively correlated with Survey Item 10, having spent time familiarizing self

with The California End of Life Option Act ($r = .44, p \leq .01$) and Survey Item 11, needing more education on the California End of Life Option Act in order to feel comfortable discussing with clients ($r = .30, p \leq .05$). Survey Item 10, having spent time familiarizing self with The California End of Life Option Act was positively correlated with Survey Item 11, needing more education on the California End of Life Option Act in order to feel comfortable discussing with clients ($r = .49, p \leq .01$). Survey Item 11, needing more education on the California End of Life Option Act in order to feel comfortable discussing with clients was strongly correlated with Survey Item 12, unsure of the NASW's best practices regarding physician assisted death ($r = .41, p \leq .01$). Lastly, there was no statistical significant correlation found between Survey Item 12, unsure of the NASW's best practices regarding physician assisted death and any of the other Survey Items.

CHAPTER FIVE

DISCUSSION

Introduction

Presented in this chapter are the conclusions drawn from the surveys that were collected from the sixty-two California medical social workers. Included in this discussion of the qualitative answers given for the research question: What is the relationship between demographic/personal characteristics, experience with a terminal illness and educational/professional training and a California social worker's perceived preparedness to discuss physician assisted dying with their clients? Further conversation will present the limitations of this research study as well as the recommendations for social work practice, implications for policies, continuance of research, and the conclusions gained from the research findings.

Discussion

The purpose of this study was to explore the influences which impact California social worker's perceived preparedness to discuss physician assisted death with their patients due to the recent California legislation legalizing this as an end of life option for some terminally ill residents. The results indicate that education and training have significant influence on California social worker's perceived preparedness to engage in professional activities involving physician

assisted death including resource linkage, brokerage and discussing physician assisted death as an end of life option with patients, family and caregivers. The findings showed a positive relationship between California social workers who perceived themselves as prepared to discuss physician assisted death and the identification of their social work education as a source of their preparedness. Additionally, the findings showed that a high level of perceived preparedness was associated with social workers who have spent time familiarizing themselves with The California End of Life Option Act and find information on this legislation to be readily available. Findings also showed a relationship between social workers who felt that their education and/or training has not prepared them to discuss physician assisted death with their clients believe that they require more education on The California End of Life Option Act in order to feel comfortable discussing this option with patients. Social workers who were older and had more years in social work practice also showed a strong relationship to perceiving their social work education as having prepared them in discussing physician assisted death. These findings were somewhat anticipated due to the newness of the legislation which forces social worker's to draw on education and training rather than professional practical experience. Supporting this assumption, the findings showed that social worker's professional interaction with terminally ill patients did not have a significant relationship to their level of perceived preparedness. Based on these findings it can be inferred that social

work education and training are the foundations that influence social worker's feelings of preparedness. These results are consistent with research findings on social worker's perceived preparedness being directly influenced by education and training (Csikai & Raymer, 2005; Kane, Hamlin, Hawkins, 2005; Csikai & Bass, 2000; Christ & Sormanti, 1999).

Another noteworthy result was that personal experience with one or more individual's diagnosed with a terminal illness was significantly associated to the belief that physician assisted death is a valid end of life option for some terminally ill patients. These findings suggest that a social worker's personal experiences and identity strongly influence their beliefs involving areas in which they may engage professionally during clinical practice. Conversely, a positive relationship was found between social worker's level of religiosity and belief that physician assisted death is a valid end of life option for some terminally ill patients. This finding was unexpected due the common assumption of Judeo-Christian condemnation of the act of taking one's life, regardless of circumstances as well as the existing research completed on physicians and nurses which identified religion as a predictive factor in their approval of physician assisted death as an end of life option (Bachman et al., 1996; Csikai, 2000; Ogden & Young, 2003 & Portenoy et al., 1997). These findings suggest that unique to other professions who address end of life options with patients, social worker's bear dual identities, both personal and professional. Additionally,

their professional identity as a social worker may, at times, bear stronger influence than that of their personal religious identity. Findings support that the label social worker is more than a professional title; social worker may be a unique identity with its own ideologies and boundaries differing from the individual identity of the social worker as a person.

Limitations

There were some limitations which were encountered during the process of this research study. One of these limitations was that The California End of Life Options Act was only recently enacted at the time participants were surveyed. There may have been a possibility that survey participants may not have been aware or exposed to the specifics of this new legislation or possessed awareness that it was newly implemented within the state that they practice social work in. The probability that this was not yet in their scope of practice could have impacted the findings.

Another limitation was in the participant professional demographic that was surveyed. Although the sample was large and diverse, involvement exclusively included nephrology social workers who served the population of dialysis patients. The study lacked diversity in the sample between types of medical social workers who may have also been frequently exposed to clients experiencing a terminal illness, such as palliative care, hospice and oncology

social workers. Including these further specialized segments of medical social workers into the research could have provided a more holistic illustration of the perceived preparedness of California social workers to discuss physician assisted death with their clients.

Recommendations for Social Work Practice, Policy and Research

It was important that this research study shed light on the perceived preparedness of California social workers to discuss physician assisted death due to the recent enactment of the new legislation and the possible changes that may heavily impact the medical social work realm. As mentioned before, the results revealed that education and training were large influences on how prepared California Social workers felt to discuss this topic with their clients. Due to these results, one recommendation that can be made is that of continuing to educate not only social work students, but social workers that are already in practice about the new law, how it impacts their role as a social worker, and how to properly approach this topic with the clients that may encounter. This may be done through the development of an educational training course to be provided by schools of social work and agencies of whom employ medical social workers serving populations of clients who may be eligible to choose this end of life option. On a macro level, the development of a California End of Life Option Act educational training course and continuing education course could be

implemented as a segment of the required social work educational curriculum, particularly as it applies to legal and ethical guidelines and ramifications to social worker's in practice in The State of California. Additionally, large health care agencies and organizations which employ social workers working with terminally ill patients may utilize this information to establish policies, procedures and guidelines surrounding the California End of Life Option Act and disseminate this information and education in an effort to standardize acceptable practices by which social worker's may gain and evaluate their own competency in practice.

Another recommendation for future research on this topic would include the development of focus groups comprised of renal, palliative care, hospice and oncology social workers. Focus groups would provide an additional benefit to this research as it would represent on a larger scale the medical social work field and their perceived preparedness to discuss physician assisted death with their clients. The findings from these groups could potentially aid in the development of future policies and procedures in social work.

The last recommendation that can be made stems from the unanticipated findings in regards to the social worker identity and the possibility that at times it may be more powerful than that of one's personal identity. This finding suggests that social work may indeed be looked upon as an actual culture. This is an area of study that has yet to be researched.

Conclusion

In the words of Miguel de Cervantes, "Forewarned, forearmed; to be prepared is half the victory." On a daily basis, California medical social workers serve as soldiers in the lives of their terminally ill patients supporting, guiding, educating, empowering and honoring their self-determination in the ending of their story, their death. This is the ultimate professional victory for a social worker, the ability to practice with competence in these impactful moments in a patient's life as a result of the preparedness received from ones social work education, training, and lived experiences. The enactment of the California End of Life Option Act has provided a new layer to the existing complexities California social workers experience when working with terminally ill patients, their families and caregivers. It has also provided these social workers with a new, valuable, resource which when used as intended by law may serve as the greatest source of empowerment some terminally ill patients may experience. Herbert Spencer said "The great aim of education is not knowledge but action." Providing California medical social workers education and training on the California End of Life Option Act serves to increase their feelings of preparedness, level of knowledge, competence in practice, and most importantly increases the level and quality of care they are able to provide to their patients.

APPENDIX A
DATA COLLECTION INSTRUMENT

Social Workers and The California End of Life Option Act

1. What is your gender?

☐ Female

☐ Male

2. What is your age?

3. What is your race/ethnicity (please check all that apply)?

☐ Non-Hispanic White

☐ Black or African-American

☐ American Indian or Alaskan Native

☐ Asian American/Pacific Islander

☐ Hispanic/Latino

☐ Other (please specify):

4. What is the highest degree you have received?

☐ Masters of Social Work (MSW)

☐ Doctor of Social Work (DSW)

☐ Other (please specify)

5. How long have you been working in the social work field?

Years

Months

6. How long have you been working in your current position?

Years

Months

7. Do you identify with any of the following religions? (Please select all that apply.)

- ☐ Protestantism
- ☐ Catholicism
- ☐ Christianity
- ☐ Judaism
- ☐ Islam
- ☐ Buddhism
- ☐ Hinduism
- ☐ Native American
- ☐ Non-denominational
- ☐ No religion
- ☐ Other (please specify)

8. How often do you attend religious or worship services, not including weddings and funerals?

- ☐ More than once a week
- ☐ Once a week
- ☐ Once or twice a month
- ☐ A few times a year
- ☐ Seldom
- ☐ Never

9. I have had professional interaction with at least one client who was diagnosed with a terminal illness

- ☐ Yes
- ☐ No

10. I have had personal experience with at least one individual (friend, family member, self, etc.) who has been diagnosed with a terminal illness

☐ Yes

☐ No

11. Please indicate how much you agree with the following statements. Use a scale where 1 =strongly disagree, 4 =neither agree nor disagree, and 7 =strongly agree. Please select only one bubble for each statement.

| | Strongly Disagree (1) | (2) | (3) | Neither Agree Nor Disagree (4) | (5) | (6) | Strongly Agree (7) |
|---|-----------------------------|-----------------------|-----------------------|--------------------------------------|-----------------------|-----------------------|--------------------------|
| My Social Work education has prepared me to discuss physician assisted death with my clients | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| All in all, I am prepared to discuss physician assisted death with clients and caregivers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| I do not feel that my education and/or training has prepared me to discuss physician assisted death with my clients | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Information on the California End of Life Option Act is readily available | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| If a client or caregiver requested information on physician assisted death, I would feel prepared | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| I am unfamiliar with the National Association of Social Workers (NASW) position on physician assisted death | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| I believe physician assisted death to be a valid end of life option for some patients in California | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| I am unsure of how I will feel if a client request resources from me on physician assisted death | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

| | Strongly Disagree (1) | (2) | (3) | Neither Agree Nor Disagree (4) | (5) | (6) | Strongly Agree (7) |
|--|-----------------------------|-----------------------|-----------------------|--------------------------------------|-----------------------|-----------------------|--------------------------|
| I feel confident knowing I am able to link patients who request information on physician assisted death with the appropriate resources | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| I have spent time familiarizing myself with the California End of Life Option Act | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| I would need more education on the California End Of Life Option Act in order to feel comfortable discussing it with my clients | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| I am unsure of the National Association of Social Worker's (NASW) best practices regarding physician assisted death | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

CREATED BY SHANDA BRENNAN AND MELIZA KINNEY

APPENDIX B
INFORMED CONSENT

INFORMED CONSENT

A Cross-Sectional Study of the Relationship Between Demographic Characteristics and Perceived Preparedness of California Medical Social Workers to Discuss Physician Assisted Death With Clients

You are invited to participate in a research study conducted by Shanda M. Brennan and Meliza Kinney from California State University, San Bernardino School of Social Work. This study has been approved by the School of Social Work subcommittee of the California State University, San Bernardino Institutional Review Board. You were selected as a participant because you are identified as a DaVita Dialysis Social Worker attending the semi-annual social worker divisional meeting. Your participation is completely voluntary and you must be over the age of 18 in order to be eligible. This form provides you with information about the study. Please read the information below and ask questions about anything you don't understand before deciding whether or not to take part in the study. We will be available to answer any questions you may have about the study.

PURPOSE:

The purpose of this study is to understand more about the relationship between demographic factors (e.g. age, gender, education, professional training and personal exposure to chronic/terminal illness) and perceptions of preparedness to discuss physician assisted death with clients.

PROCEDURES:

If you volunteer to participate in this study, we will ask you to complete a survey. Some of the survey items include the following statements and we will ask you if you agree or disagree with them:

- I feel prepared to discuss physician assisted death with a client or caregiver who initiates the discussion
- I have received professional training on physician assisted death as an end of life option

It should take you about 10 minutes to complete the survey. You can return the survey to the indicated drop box; location will be announced at the beginning of the meeting. PLEASE RETURN THIS FORM WITH THE CONSENT BOX MARKED ALONG WITH YOUR SURVEY.

POTENTIAL RISKS:

Some of the questions asked in the survey may be potentially distressing since they involve sensitive and controversial subject matter. You do not need to answer any questions that you may find uncomfortable.

909.537.5501

5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

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College of Social and Behavioral Sciences
School of Social Work

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY:

You may not directly benefit from your participation in the study. Your participation will help improve the understanding of what factors may influence perceptions of preparedness to discuss physician assisted death with clients.

PAYMENT/COMPENSATION FOR PARTICIPATION:

If you choose to participate, you will be eligible to enter a drawing for a \$25 dollar gift card. Four gift cards will be (Starbucks (2) & Target (2)) drawn at the end of the meeting. Please submit your survey to us with your completed drawing ticket. You must be present for the drawing at the end of the meeting to be eligible to participate.

PARTICIPATION AND WITHDRAWAL:

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study.

RIGHTS OF RESEARCH SUBJECTS:

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights, or remedies because of your participation in this research study. If you have questions regarding your rights as a research subject, contact the Prof. Janet Chang, Ph.D., MSW, IRB Member/IRB Chair of Social Work IRB Committee, 909-537-5184, jchang@csusb.edu.

IDENTIFICATION OF INVESTIGATORS:

If you have any questions or concerns about the research, please feel free to contact Dr. Erica Lizano at: California State University, San Bernardino, 5500 University Parkway, San Bernardino, CA 92407, tel: 909-537-5584, email: elizano@csusb.edu

CONFIDENTIALITY:

All personal information is strictly confidential. Any findings will be reported will be in aggregate form, which means everyone's answers will be put together. Your name will not be used or placed with your answers. Additionally, the specific location of the data collection will not be included in any presentation or publications.

RESEARCH PARTICIPANT CONSENT

☐ By checking this box I agree to participate in this study. Date: _____

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APPENDIX C

CORRELATION MATRIX OF STUDY VARIABLES

Table 2. Correlation Matrix

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|--|-------|-------|-------|-------|-------|-------|-------|------|-------|------|
| 1. Sex | 1.00 | | | | | | | | | |
| 2. Age | 0.01 | 1.00 | | | | | | | | |
| 3. Race | -0.23 | -0.11 | 1.00 | | | | | | | |
| 4. Education Level | -0.12 | -0.03 | 0.05 | 1.00 | | | | | | |
| 5. Social Work Experience | 0.02 | .73** | 0.01 | -0.11 | 1.00 | | | | | |
| 6. Years in Current Job Position | 0.10 | .55** | -0.17 | -0.18 | .54** | 1.00 | | | | |
| 7. Religious Identification | 0.06 | -0.05 | -0.15 | 0.11 | -0.02 | -0.01 | 1.00 | | | |
| 8. Religiosity | 0.18 | -0.05 | .29** | .32* | -0.17 | 0.02 | .30* | 1.00 | | |
| 9. Professional Experience With Terminal Illness | -0.04 | -0.14 | 0.12 | .36** | -0.17 | -0.11 | -0.10 | 0.11 | 1.00 | |
| 10. Personal Experience With Terminal Illness | 0.15 | -0.26 | -0.02 | -0.16 | -0.20 | -0.23 | 0.17 | 0.24 | -0.06 | 1.00 |

****.** *Correlation is significant at the $p \leq 0.01$ level (2-tailed).*

***.** *Correlation is significant at the $p \leq 0.05$ level (2-tailed).*

Table 2 Correlation matrix continued

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|--|-------|--------------|-------|--------------|-------------|------|------|-------|---------------|-------|
| 1. Sex | | | | | | | | | | |
| 2. Age | | | | | | | | | | |
| 3. Race | | | | | | | | | | |
| 4. Education Level | | | | | | | | | | |
| 5. Social Work Experience | | | | | | | | | | |
| 6. Years in Current Job Position | | | | | | | | | | |
| 7. Religious Identification | | | | | | | | | | |
| 8. Religiosity | | | | | | | | | | |
| 9. Professional Experience With Terminal Illness | | | | | | | | | | |
| 10. Personal Experience With Terminal Illness | 0.06 | .28* | 0.04 | -0.11 | .31* | 0.14 | 0.01 | -0.20 | -0.19 | -0.13 |
| 12. Item Two | 0.07 | 0.24 | -0.01 | -0.07 | 0.23 | 0.05 | 0.20 | -0.08 | -0.22 | -0.17 |
| 13. Item Three | 0.02 | 0.10 | 0.03 | .30** | 0.16 | 0.13 | 0.19 | -0.19 | -0.26* | -0.07 |
| 14. Item Four | -0.16 | .39** | -0.01 | 0.07 | .29* | 0.12 | 0.00 | -0.04 | 0.06 | -0.24 |

****.** Correlation is significant at the $p \leq 0.01$ level (2-tailed).

***** Correlation is significant at the $p \leq 0.05$ level (2-tailed).

Table 2 Correlation matrix continued

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|-----------------|-------|--------------|--------------|-------|-------------|-------------|-------------|--------------|-------|--------------|
| 15. Item Five | 0.01 | .34* | -0.11 | 0.01 | 0.23 | 0.10 | 0.05 | 0.00 | -0.13 | -0.18 |
| 16. Item Six | -0.22 | -0.04 | 0.08 | 0.04 | -0.07 | -0.08 | -0.22 | -0.21 | -0.18 | -0.21 |
| 17. Item Seven | -0.11 | 0.17 | -0.18 | 0.18 | 0.07 | 0.01 | 0.21 | .50** | 0.03 | .31* |
| 18. Item Eight | -0.18 | 0.06 | -.29* | -0.24 | -0.08 | 0.08 | .26* | 0.01 | -0.19 | 0.22 |
| 19. Item Nine | 0.03 | 0.20 | -0.22 | 0.21 | 0.17 | 0.04 | 0.02 | -0.04 | 0.05 | -.30* |
| 20. Item Ten | -0.24 | .49** | -0.15 | 0.10 | .32* | .28* | 0.08 | -0.04 | -0.14 | -.35* |
| 21. Item Eleven | -0.07 | 0.22 | -0.18 | 0.04 | 0.05 | 0.16 | 0.23 | -0.17 | -0.11 | -.29* |
| 22. Item Twelve | -0.19 | .32* | .27* | -0.09 | .30* | 0.15 | -0.10 | -.26* | -0.13 | -0.19 |

****.** *Correlation is significant at the $p \leq 0.01$ level (2-tailed).*

*****. *Correlation is significant at the $p \leq 0.05$ level (2-tailed).*

**Table 2 Correlation matrix
continued**

| | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
|-----------------|--------------|--------------|--------------|--------------|--------------|-------|-------------|-------------|--------------|--------------|--------------|------|
| 11. Item One | 1.00 | | | | | | | | | | | |
| 12. Item Two | .59** | 1.00 | | | | | | | | | | |
| 13. Item Three | .46** | .38** | 1.00 | | | | | | | | | |
| 14. Item Four | 0.24 | .40** | 0.17 | 1.00 | | | | | | | | |
| 15. Item Five | .43** | .71** | .35** | .49** | 1.00 | | | | | | | |
| 16. Item Six | 0.04 | 0.05 | - 0.06 | - 0.03 | 0.11 | 1.00 | | | | | | |
| 17. Item Seven | 0.01 | 0.08 | - 0.11 | 0.20 | 0.24 | -0.15 | 1.00 | | | | | |
| 18. Item Eight | - 0.04 | - 0.04 | 0.13 | 0.08 | 0.09 | 0.14 | .25* | 1.00 | | | | |
| 19. Item Nine | 0.24 | .40** | 0.00 | .35** | .50** | 0.13 | 0.12 | 0.09 | 1.00 | | | |
| 20. Item Ten | .36** | .44** | .26* | .61** | .53** | 0.14 | 0.15 | 0.05 | .44** | 1.00 | | |
| 21. Item Eleven | - 0.01 | .27* | .29* | .35** | .32* | 0.17 | -0.12 | .31* | .30* | .49** | 1.00 | |
| 22. Item Twelve | 0.17 | .31* | .31* | 0.22 | .36** | .31 | -0.08 | -0.02 | 0.25 | 0.42 | .41** | 1.00 |

****.** Correlation is significant at the $p \leq 0.01$ level (2-tailed).

***.** Correlation is significant at the $p \leq 0.05$ level (2-tailed).

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ASSIGNED RESPONSIBILITIES

This was a two-person project where authors collaborated throughout. Although collaboration was utilized, for certain stages of the project creators took upon primary responsibility. These responsibilities were assigned as listed below:

1. Data Collection:

Team Effort: Shanda Brennan and Meliza Kinney

2. Data Entry and Analysis

Team Effort: Shanda Brennan and Meliza Kinney

3. Writing Report and Presentation of Findings:

- a. Introduction And Literature

Assigned Leader: Shanda Brennan

Assisted By: Meliza Kinney

- b. Methods

Team Effort: Shanda Brennan and Meliza Kinney

- c. Results

Team Effort: Shanda Brennan and Meliza Kinney

- d. Discussion

Team Effort: Shanda Brennan and Meliza Kinney