

**Togolese Lay People's and Health Professionals' Views about the Acceptability of
Physician-Assisted Suicide**

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ABSTRACT

Aim: To study the views of lay people and health professionals in an African country, Togo, of the acceptability of physician-assisted-suicide (PAS).

Method: In February-June 2012, 322 lay people and 198 health professionals (75 physicians, 60 nurses, and 63 health counselors) in Togo judged the acceptability of PAS in 36 concrete scenarios composed of all combinations of four factors: (a) the patient's age, (b) the level of incurability of the illness, (c) the type of suffering, and (d) the patient's request for PAS. In all scenarios, the patients were women who were receiving the best possible care. The ratings were subjected to cluster analysis and analyses of variance.

Results: The majority of lay people (59%) were not systematically opposed to PAS, whereas the majority of health professionals (80%) working in the same area were opposed to it. The most important factors in increasing acceptability among people who were not systematically opposed were advanced age of the patient and untreatability of the illness. Additional acceptability was provided by the patient's request to have her life ended, although much so less than in studies in Western countries, and suffering characterized by complete dependence rather than by extreme physical pain.

Conclusion: These empirical findings --the first ones gathered in the African continent-- suggest that most Togolese lay people are not categorically for or against PAS, but judge its degree of acceptability as a function of concrete circumstances.

Keywords: Physician-assisted suicide; Acceptability; Empirical study; Scenarios; Togo

INTRODUCTION

Whether physicians or other caregivers should intervene to end terminally-ill patients' lives has always been controversial both among the public and among health care providers. In euthanasia, physicians intervene directly and purposely to end patients' lives whereas in physician-assisted suicide (PAS) physicians provide patients with the means to end their lives by themselves. Recent legislation regulates (a) PAS in Germany, in Switzerland, and in the US states of Oregon, and Washington, (b) euthanasia in Belgium and Colombia, and (c) both euthanasia and PAS in the Netherlands and Luxembourg.^{1 2} Similar legislation is under discussion in other U.S. states and elsewhere in the world (e.g., South Africa).³

Public Opinion in Western Countries

Most studies of public opinion about the acceptability of PAS or euthanasia have been performed in North America or in Western Europe.¹ Most of them have used questionnaires. For instance, in a survey conducted in 33 European countries,⁴ participants were instructed to rate the extent to which they consider that terminating the life of the incurably sick can be justified using a 10 point scale ranging from "can never be justified" to "can always be justified". Mean ratings ranged from 2.23 (Malta) to 6.68 (Netherlands).

In other studies, the cognitive process involved in acceptability judgments has been analyzed. For example, Teisseyre and colleagues⁵ presented French lay people and health professionals (physicians and nurses) with concrete scenarios depicting the condition of terminally ill patients. The information included the patients' life expectancy, the patient's willingness to undergo organ donation, the extent to which the patient requested a life-ending procedure, and the family's attitude towards prolonging treatment. They found that the acceptability of euthanasia depended additively on these four factors and that the presence or

absence of a request from the patients was by far the most important factor. They also showed that for the majority of participants (75%), acceptability depended on circumstances, whereas the minority considered euthanasia was never acceptable or as always acceptable.

Public Opinion in Non-Western Countries

Few data reflecting the opinions of people living in non-Western country are available. Kamble and colleagues⁶ applied the methodology used by Teisseyre and colleagues⁵ to the question of the acceptability of PAS to people in India. They presented university students with vignettes depicting the patient's type of suffering (extreme physical pain or complete dependence), the level of curability of the illness, age, and the extent of request for a life-ending procedure. For 29% of the participants, PAS was mainly unacceptable, but less so if the patient was older or requested it. For 29%, it was mainly acceptable, but less so if the patient was younger or did not request it. For 42%, it was clearly unacceptable if the patient was young but was clearly acceptable if elderly, and more so if the patient requested it. The patient's age was thus the main determinant of acceptability, which was consistent with the Hindu philosophy of reincarnation according to which death is not the end of life but a simple transition, through rebirth, between two successive lives in two different bodies.⁷

No empirical data exists regarding African people's views of end-of-life decisions, despite the high prevalence of lethal illnesses such as AIDS⁸ or cancer⁹ and the growing public sensibility to 'a right to die' for terminally ill patients.^{13 10} As recently stated by Myani¹¹ (p. 4): "In Africa, the question of euthanasia and the tempo for the discourse on this controversial issue must be set; and more than any other sector of the society, lawyers must set the tone. This issue, which though will definitely cause mental, moral and professional consternation, cannot be left untouched. After all, we know that the ostrich never escapes danger by hiding its head between

its legs... Africa must take a stand” (see also Nwafor¹²). In Africa, PSA or euthanasia is illegal: assisting a patient to die is considered as murder. There is, however, ample evidence showing that unauthorized euthanasia is taking place.¹³ It is important therefore, for policy makers and caregivers in these countries to appreciate under which conditions life-ending actions are or are not acceptable both to the public and to the health care community.

The Present Study

The aim of the present study was to analyze the views of lay people and health professionals living in Western Africa – namely Togo – on the acceptability of PAS in the case of patients either in a state of complete dependence or suffering from intractable pain, using the material that had already been used by Ahmed and colleagues¹⁴ and Kamble and colleagues.⁶ Togo is a Francophone country that is located in the west coast of Africa. With a population of approximately 6.2 million, Togo’s Human Development Index was .43 in 2011, which gives the country a rank of 162 out of 187 countries.¹⁵ The average life expectancy at birth is approximately 57 years.¹⁵

Our first research question was, to what extent would views about the acceptability of PAS differ among participants, and particularly between lay people and health professionals? We anticipated finding a variety of views that reflect the diversity of opinions within the country. In particular, based on the findings of Ahmed and colleagues¹⁴ and Kamble and colleagues,⁶ we expected to find at least two positions: a majority view that acceptability must be a function essentially of circumstances (e.g., the timing of death), and a minority view that PAS is never permissible. We also expected, based on the findings by Teisseyre and colleagues,⁵ that health

professionals would, more often than lay people, express the opinion that PSA is never acceptable, irrespective of circumstances.

Our second research question was, among participants who consider that PSA can be acceptable, what are the factors that impact their acceptability judgments? We expected that (a) PAS by old patients who are dying and suffering (or completely dependent) would be considered as more acceptable than PAS by young patients, even if they are truly dying and are experiencing much physical and psychological suffering, because of traditional beliefs that old persons who die become ancestors, that is, “living dead” members of society;¹⁶ (b) PAS by patients whose illness is totally incurable would be considered as more acceptable than by patients whose illness is very difficult to treat, and finally (c) PAS by patients who repeatedly requested a life-ending procedure would be considered as more acceptable than by patients who did not explicitly request it.

METHODS

Participants

The participants were unpaid volunteers living in greater Lomé, the capital city of Togo. The lay participants were approached by one of eight research assistants while they were walking along the main sidewalks of Lomé. The health professionals were contacted at the region’s three public hospitals where they work. They were informed about the goals of the study and gave their consent. Overall 400 lay people and 300 health professionals were contacted, and after having received a full explanation of the study and its procedure, 75% of the lay people (322 people) and 69% of the health professionals (75 physicians, 60 nurses, and 63 health counselors) agreed to participate. The mean age of the 510 participants (298 men and 212 women) was

33.71 years (SD=11.15, range=18-70). Among the lay people, 22% had a university degree, 69% a secondary level degree, and 9% a primary level degree. Concerning religious belief, 57% of the lay people identified themselves as Christian, 33% as Muslim, 6% as Animist (Voodoo), and 4% as atheist.

Material

The material consisted of 36 cards containing a vignette of a few lines, a question, and a response scale. The vignettes were composed according to a four within-subject factor design: Age x Incurability x Type of Suffering x Request, 3 x 2 x 2 x 3. These information items were in the following order: (a) the patient's age (35, 60, or 85 years), (b) the level of incurability (or curability) of the illness (completely incurable or extremely difficult to cure), (c) the type of suffering (extreme physical pain or complete dependence), and (d) the extent to which the patient requests a life-ending procedure, euthanasia or PAS (no request, some form of request, or repeated formal requests). The question was, "To what extent do you believe that physician-assisted suicide would be an acceptable procedure in this case?" The response scale was a 15-point scale with anchors of "Not acceptable at all" and "Completely acceptable." Two examples are given in the Appendix. The cards were rearranged in random order for each participant.

Procedure

The site was for the lay people either a vacant classroom in the local university or the participant's private home; and for the health professionals, it was a vacant room in the hospital. Each person was tested individually, and the procedure was the one used in previous studies.^{17 18} In a so-called familiarization phase, the research assistant explained to the participants what was expected, i.e., that they were to read a certain number of vignettes in which a person who is suffering from an illness that is extremely difficult to treat or incurable does or does not express

a desire to die and that for each scenario they were to indicate the degree of acceptability of a decision to resort to PAS. Next, the participants were given 12 vignettes taken randomly from the complete set. They read each vignette, after which the first author reminded them of the items of information in the vignette. The participants then made an acceptability rating. After completing the 12 ratings, they were allowed to look back at their responses and change them.

In the main study phase, the participants were given the whole set of 36 vignettes. They made ratings at their own pace but were not allowed to compare their responses nor to go back and make changes. In both phases, the research assistant made certain that the participants understood all relevant information before they made ratings. The participants took 15-30 minutes to complete both phases.

The research was approved by representatives of the Ministry of Research and Higher Education and the Ministry of Health, and informed consent was obtained from all the participants in the study.

RESULTS

To look for groupings of participants, a cluster analysis was performed on the raw data in accordance with the recommendations of Hofmans and Mullet;¹⁹ that is, we used K-means clustering (Euclidian distances), a nonhierarchical centroid-based method. Two clusters of participants were identified. They are described in Table 1 and shown in Figure 1, with mean acceptability ratings pooled across levels of types of suffering. The first cluster ($N=291$) was termed *Never Acceptable* since the responses were always closer to the left side than to the right side of the acceptability scale. The mean value of the responses was 2.08 ($SD=2.65$), out of 15.

The second cluster ($N=219$), was termed *Depending on Circumstances*. The mean value of the responses was 8.05 ($SD=2.36$). As shown in Figure 1 (bottom panels), the responses clearly depended on the patient's age (the curves are extremely separated), on request (the curves are ascending), and on incurability (the set of curves in the right panel are higher than the set of curves in the left panel). Differences in the demographic composition of these clusters were assessed with Chi-square statistics. The only significant difference was, as expected, between lay people and health professionals. The percentage of health professional in the Never Acceptable cluster was higher (80%) than the percentage of lay people (41%), $Chi^2(1)=74.20, p<.001$. The percentages of types of health professionals—71% of the nurses, 90% of the health counselors, and 79% of the physicians—did not differ significantly.

An ANOVA was performed on the raw data using STATISTICA (see Table 2). The design was Cluster x Age x Incurability x Type of Suffering x Request, $2 \times 3 \times 2 \times 2 \times 3$. Cluster was a between-subject factor. The other factors were within-subject factors. Owing to the great number of comparisons conducted, the significance threshold was set at .001 (.05/31) using the Bonferroni technique.

The cluster effect was significant (see above). The type of suffering factor was significant. When the patient was completely dependent, acceptability was higher ($M=5.40, SD=1.93$) than when the patient was suffering from physical pain ($M=4.73, SD=2.19$) (a difference in means of 0.67 points). The curability factor was significant. When the patient was completely incurable, acceptability was higher ($M=5.89, SD=1.73$) than when the illness was difficult to treat ($M=4.25, SD=1.95$) (a difference in means of 1.64 points). The request factor was significant. When request was present and repetitive, acceptability was higher than when it was not repetitive or there was no request. Post-hoc analyses using the Tuckey honestly

significant difference test showed that the mean acceptability value observed when request was present but not repetitive ($M=5.04$, $SD=2.01$) differed significantly from the mean values observed in the two other cases, $p < .001$. It was intermediate between the acceptability values observed when request was repetitive ($M=5.99$, $SD=2.07$) and when there was no request ($M=4.16$, $SD=1.52$). The difference between the mean ratings for repetitive request and no request was 1.83 points. The patient's age factor was significant. When the patient was 85, acceptability was higher than when she was 60 or 35. Post-hoc analyses showed that the mean acceptability value observed when the patient was 60 ($M=5.28$, $SD=1.59$) significantly differed from the mean values observed in the two other cases, $p < .001$. It was intermediate between the acceptability values observed when the patient was 85 ($M=6.28$, $SD=1.66$) and when she was 35 ($M=3.64$, $SD=1.52$). The difference between the mean ratings at age 85 and age 35 was 2.64 points.

The Cluster x Type of suffering interaction was significant. The effect of type of suffering was weaker in the *Never Acceptable* cluster (a difference of 0.39 between the highest and lowest acceptability level) than in the *Depending on Circumstances* cluster (a difference of 1.05). Post-hoc analyses conducted at the level of each cluster showed, however, that effect of type of suffering was significant in both clusters, $F(1,290)=27.25$, $p<.001$, $\eta^2_p=.09$, and $F(1,218)=66.60$, $p<.001$, $\eta^2_p=.23$, respectively. The Cluster x Curability interaction was significant. The effect of curability was weaker in the *Never Acceptable* cluster (a difference of 0.24 between the highest and lowest acceptability level) than in the *Depending on Circumstances* cluster (a difference of 3.04). Post-hoc analyses conducted at the level of each cluster showed, however, that effect of type of suffering was significant in both clusters, $F(1,290)=21.04$, $p < .001$, $\eta^2_p=.07$, and $F(1,218)=181.13$, $p < .001$, $\eta^2_p=.45$, respectively.

The Cluster x Request interaction was significant. The effect of the request factor was weaker in the *Never Acceptable* cluster (a difference of 0.55 between the highest and lowest acceptability level) than in the *Depending on Circumstances* cluster (a difference of 3.10). Post-hoc analyses conducted at the level of each cluster showed, however, that the Request effect was significant in both clusters, $F(2,580)=14.27, p < .001, \eta^2_p=.07$, and $F(2,436)=157.57, p < .001, \eta^2_p=.42$, respectively. The Cluster x Age interaction was significant. The effect of the age factor was weaker in the *Always Unacceptable* cluster (a difference of 0.73 between the highest and lowest acceptability level) than in the *Depending on Circumstances* cluster (a difference of 4.55). Post-hoc analyses conducted at the level of each cluster showed that the Age effect was significant in both clusters, $F(2, 580)=33.01, p < .001, \eta^2_p=.10$, and $F(2,436)=214.29, p<.001, \eta^2_p=.50$, respectively.

The Request x Age and the Curability x Request x Age interactions were significant. As illustrated in Figure 1 (bottom panels), when the illness is difficult to treat, the effect of age varies as a function of the level of the request factor (curves are diverging on the right). In contrast, when the illness is completely incurable, the effect of age is constant across the three levels of the request factor (curves are roughly parallel). Other interactions were significant but the effect sizes associated with them were very small.

DISCUSSION

The present study examined the views of lay people and health professionals living in Togo, West Africa, on the acceptability of PAS in the case of patients suffering from intractable pain or in a state of complete dependence. The first research question concerned the extent to which views about the acceptability of PAS differ among participants. Two very different

positions were found. As expected, among lay people, the majority position was “acceptability depends on circumstances”. This finding was consistent with the findings by Kamble and colleagues⁶ on Indian students and Muñoz Sastre and colleagues²⁰ on French adults, and in contrast to the findings by Ahmed and colleagues¹⁴ on Kuwaiti students. As also expected, the majority position among health professionals was “never acceptable,” consistent with findings by Teisseyre and colleagues.⁵

The second research question was the extent to which each of the four factors considered in the study -- patient’s age, the curability of the illness, the type of suffering, and the extent of patient requests to end her life -- impacts acceptability judgments among participants for whom PSA can be considered as an acceptable procedure. Overall, it was found that all factors impacted significantly but that two of them – patient’s age and curability – had more impact. The great importance given to patient’s age is consistent with the findings by Kamble and colleagues⁶ but cannot be explained in the same way. In Togolese culture, the age of the dead person is important since it helps to distinguish between a “good” death and a “bad” one. Death of a young person is considered premature and ‘unnatural’, and it leads to a partial destruction of social cohesion. Death in this case is seriously mourned, and no formal rituals are associated with burial.²¹ In contrast, death of an old person is considered a great blessing for the whole society since such a death is considered a ritual of passage into becoming an ancestor. Ancestor status is the highest stage of the developmental trajectory of personhood.^{16 22}

The great importance given to curability of the illness is a new finding. In studies conducted in France^{17 20} or India,⁶ the curability factor was significant but its effect was limited in size. In Togo and in Western Africa generally, medical facilities are scarce. As a result, the curability of the illness factor has possibly been attributed a great importance because illnesses

that are considered as treatable in Europe or North America can be too quickly considered as untreatable in Togo, owing to lack of equipment.

The limited importance given to patient's request is consistent with the findings by Kamble and colleagues⁶ and Ahmed and colleagues,¹⁴ but it is in sharp contrast to the findings in studies on Westerners^{5 17 20} that have repeatedly shown that, in decisions about ending life, the principle of patient autonomy tends to dominate the other principles of medical ethics. As explained by Blank²³ (p. 204): "Three-quarters of the world's population is not linked to concepts such as individual autonomy and truth telling that are assumed by the conventional western bioethics community as critical in medicine." The present findings nicely illustrate Blank's concerns.

Finally, the importance given to the type of suffering is also a new finding. In other studies (e.g., Kamble and colleagues⁶), participants did not consider that completely dependent people should be treated differently from people suffering from physical pain. Among Togolese, however, PAS was more acceptable in the case of complete dependence. This finding can also be related to the scarcity of medical facilities and the expense of medical care in Togo. Maintaining alive persons who are completely dependent and who wish to end their lives might have appeared nonsensical in a context in which other patients who could be successfully treated are unable to obtain treatment owing to lack of resources.

The study has, of course, limitations. First, the group of participants was a convenience sample and was of only moderate size. Second, geographic location may play a role, i.e., the judgments of people living in the capital city may differ from those of people living in other parts of the country. Third, the participants responded to vignettes, not to real patients. The use of vignettes, however, is useful—it permits statistical analyses to reveal how people weight and

combine separate factors—and has been validated.²⁴ Fourth, the experimenter did not ask further questions to elucidate the reasons, no doubt both personal and cultural, for the participants' responses.

In summary, (a) a majority of people living in Lomé, Togo, do not appear to be systematically opposed to PAS, whereas a majority of health professionals working in the same area are opposed to it; (b) the most important factors in increasing acceptability among people who were not systematically opposed were advanced age of the patient and untreatability of the illness; (c) additional acceptability was provided by the patient's request to have her life ended, although much so less than in studies in Western countries, and suffering characterized by complete dependence rather than by extreme physical pain. These empirical findings--the first ones gathered in the African continent--can be useful for policy makers and jurists by enabling them to take a more nuanced view of PAS.

References

1. Blank RH, Merrick J. *End-of-life decision making: A cross-cultural study*. Cambridge, MS: MIT Press, 2005.
2. McDougall JF, Gorman M. *Contemporary World Issues: Euthanasia*. Santa Barbara, California: ABC-CLIO, 2008.
3. Brits L, Human L, Pietersee L, *et al.* Opinions of private medical practitioners in Bloemfontein, South Africa, regarding euthanasia of terminally-ill patients. *J Med Ethics* 2009;35:180-2.
4. Cohen J, Marcoux I, Bilsen J, *et al.* European public acceptance of euthanasia: Socio-demographic and cultural factors associated with the acceptance of euthanasia in 33 European countries. *Soc Sci Med* 2006;63:743-56.
5. Teisseyre N, Mullet E, Sorum PC. Under what conditions is euthanasia acceptable to lay people and health professionals? *Soc Sci Med* 2005;60:357-68.
6. Kamble S, Sorum PC, Mullet E. Young Indians' views of the acceptability of physician-assisted suicide. *Int Perspect Psychol* 2012;1:165-76.
7. Firth S. End-of-life: a Hindu view. *Lancet* 2005;366:682-6.
8. World Health Organization. *HIV/AIDS. Fact sheet N° 360*. Geneva: WHO, 2012.
<http://www.who.int/mediacentre/factsheets/fs360/en/index.html#>, accessed 12 November 2012.
9. Jemal A, Bray F, Center MM, *et al.* Global cancer statistics. *CA Cancer J Clin* 2011;61:69-90.
10. Hosking M, Whiting G, Brathwate C, *et al.* Cultural attitudes towards death and dying: A South African perspective. *Palliat Med* 2000;14:437-9.

11. Myani B. Mercy killing: Africa and the question of euthanasia. *The Lawyer's Chronicle: the Magazine for the African Lawyer* [eLetter]. Accessed 23 October 2012
http://thelawyerschronicle.com/index.php?option=com_content&view=article&id=77:mercy-killing-africa-and-the-question-of-euthanasia&catid=35:focus-on-the-law&Itemid=53
12. Nwafor AO. Comparative perspectives on euthanasia in Nigeria and Ethiopia. *Afr J Intl Comp L* 2010;18:170-91.
13. Bamgbose O. Euthanasia: Another face of murder. *Int J Offender Ther Comp Criminol* 2004;48:111-21.
14. Ahmed RA, Sorum PC, Mullet E Young Kuwaitis' views of the acceptability of physician-assisted-suicide. *J Med Ethics* 2010;36:671-6.
15. United Nations Development Programme. *International human development indicators: Country facts sheets*. New York: UNDP, 2011.
<http://hdrstats.undp.org/en/countries/profiles/TGO.html>, accessed 04 November 2012.
16. Kalu OU. Ancestral spirituality and society in Africa. In: Olupona JK, ed. *African traditional religions. Forms, meanings and expressions*. New York: The Crossroad Publishing Company 2000:54-86.
17. Frileux S, Lelièvre C, Muñoz Sastre MT, et al. Deciding to end a patient's life. *J Med Ethics* 2003;29:330-6.
18. Teisseyre N, Duarte dos Reis I, Sorum PC, et al. The acceptability among French lay persons of ending the lives of damaged newborns. *J Med Ethics* 2009;35:701-8.
19. Hofmans J, Mullet E. Towards unveiling individual differences in different stages of information processing: A clustering-based approach. *Qual Quant* 2011; Epub June 30, 2011.

20. Muñoz Sastre MT, Gonzalez C, Lhermitte A, et al. Do ethical judgments depend on the type of response scale? Comparing acceptability versus unacceptability judgments in the case of life-ending procedures. *Psicologica* 2010;31:529-39.
21. Moore AR. Older poor parents who lost an adult child to AIDS in Togo, West Africa: A qualitative study. *Omega* 2007;56:289-302.
22. Paris PJ. *The spirituality of African peoples*. Minneapolis, MN: Augsburg Fortress, 1995.
23. Blank RH. End-of life decision making across cultures. *J Law Med Ethics* 2011;2:201-14.
24. Fruchart E, Rulence-Pâques P, Mullet E. Ecological validity test of laboratory studies on information integration. *Teor Model* 2007;12:281-8.

Table 1.

Composition of the two clusters of positions on PAS in relation to participants' sex, religious affiliation, and profession.

| Characteristics | Clusters | | Total |
|-------------------|------------------|----------------------------|-------|
| | Never Acceptable | Depending on Circumstances | |
| Females | 165 (55%) | 133 (45%) | 298 |
| Males | 126 (59%) | 86 (41%) | 212 |
| Christians | 183 (58%) | 133 (42%) | 316 |
| Muslims | 86 (58%) | 61 (42%) | 147 |
| Animists | 14 (50%) | 14 (50%) | 28 |
| Atheists | 8 (42%) | 11 (58%) | 19 |
| Lay People | 125 (41%) | 177 (59%) | 302 |
| Nurses | 50 (71%) | 20 (29%) | 70 |
| Health Counselors | 57 (90%) | 6 (10%) | 63 |
| Physicians | 59 (79%) | 16 (21%) | 75 |
| Mean Age | 35.24 | 31.67 | |
| Total | 291 | 219 | 510 |

Table 2.

Main Results of the ANOVA. Effects sizes for the higher-order interactions were lower than .015.

| Factors | <i>df</i> | <i>MS</i> | <i>F</i> | <i>p</i> | η^2_p |
|-----------------------|-----------|------------|----------|----------|------------|
| Cluster (C) | 1 | 160 628.77 | 1 471.75 | .001 | .74 |
| Type of Suffering (T) | 1 | 2 014.68 | 108.55 | .001 | .17 |
| Incurability (I) | 1 | 12 112.75 | 256.09 | .001 | .34 |
| Request (R) | 2 | 5 009.84 | 162.02 | .001 | .24 |
| Patient's Age (A) | 2 | 10 638.71 | 295.05 | .001 | .37 |
| C x T | 1 | 657.40 | 35.42 | .001 | .07 |
| C x I | 1 | 8 828.94 | 186.66 | .001 | .27 |
| T x I | 1 | 112.02 | 10.21 | NS | .02 |
| C x R | 2 | 2 542.62 | 82.23 | .001 | .14 |
| T x R | 2 | 104.71 | 11.77 | .001 | .02 |
| I x R | 2 | 54.36 | 4.46 | NS | .01 |
| C x A | 2 | 5 759.71 | 159.74 | .001 | .24 |
| T x A | 2 | 81.51 | 6.69 | NS | .01 |
| I x A | 2 | 11.26 | 1.01 | NS | .00 |
| R x A | 4 | 261.07 | 25.87 | .001 | .05 |

Figure captions

Figure 1

Patterns of results corresponding to the Never Acceptable cluster (top panels), and to the Depending on Circumstances cluster (bottom panels). In each panel, (a) the mean acceptability judgments are on the y-axis, (b) the three levels of patient request are on the x-axis, (c) the three curves correspond to the three levels of patient age, and (d) the two panels correspond to the two levels of the curability factor.

