Debating Death: Religion, Politics, and the Oregon Death With Dignity Act

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In 1994, Oregon passed the Oregon Death With Dignity Act, becoming the first state in the nation to allow physician-assisted suicide (PAS†). This paper compares the public discussion that occurred in 1994 and during the Act’s implementation in 1997 and examines these debates in relation to health care reform under the Obama administration. I argue that the 1994 and 1997 Oregon PAS campaigns and the ensuing public debate represent the culmination of a growing lack of deference to medical authority, concerns with the doctor-patient relationship, and a desire for increased patient autonomy over decisions during death. The public debate over PAS in Oregon underscored the conflicts among competing religious, political, and personal interests. More visible and widespread than any other American debate on PAS, the conflict in Oregon marked the beginning of the now nationwide problem of determining if and when a terminally ill person can choose to die.

INTRODUCTION

“In his final months, Emerson lived in agony, unable . . . to end his own suffering. His bones became so brittle that they broke when he turned over. He lived in constant pain, no matter how much morphine was prescribed. My husband of 40 years died exactly the death he feared” [1].

Individual testimonies like this one, found in a “Measure 51 Arguments in Opposition” voters’ packet published by the Oregon Secretary of State Elections Division, were crucial to the pro-physician-assisted suicide campaigns in Oregon in 1994 and 1997. In 1994, Oregon passed the Oregon Death With Dignity Act, legalizing physician-assisted suicide (PAS) for terminally ill Oregon residents. Between the passing of the Act and its eventual implementation in 1997, a rivalry between socially liberal groups and conservative religious organizations developed. Politically liberal organizations that supported the Act drew on public hostility against the Catholic Church and depicted PAS as both a right that respected individual autonomy and
as a more dignified way of facing death. By patient autonomy, I refer to what the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research terms “patient sovereignty” [2] or “patient choice and control over medical decisions” [3]. Religious groups in opposition to PAS presented aid-in-dying as a threat to morality and introduced practical concerns that clinical techniques were ineffective.

This paper compares the public debate that occurred in 1994 and during the Oregon Death With Dignity Act’s eventual enactment in 1997. The public discussion surrounding PAS in Oregon had far-reaching implications, and rhetoric from the campaigns would be repeated in discussions of national health care reform under the Obama administration. I argue that the 1994 and 1997 Oregon PAS campaigns and the subsequent public debate demonstrate a declining trust in the medical profession, competing claims to medical expertise, and a desire for individual choice and control during death. This public discussion underscored the conflicts among competing religious, political, and personal interests and brought to the foreground questions of physician authority, dignified death, and the limits of modern medicine.

In Dying Right, authors Daniel Hillyard and John Dombrink provide a thorough overview of the 1994 and 1997 physician-assisted suicide campaigns in Oregon and devote significant space to examining the political strategies of both sides of the campaigns [4]. The authors correctly point to a number of themes that were ongoing in these debates, including individual rights, religious hostility, clinical failure, and the morality of PAS. However, Dying Right touches on these themes only briefly; this paper seeks to provide additional evidence of the underlying tensions on both sides of the campaign and to highlight new aspects such as individual testimonies, concerns over terminally ill misdiagnoses, and grassroots activism. It will then seek to add a more substantial analysis of the 1997 campaign, which was only briefly examined in Dying Right. This paper also argues, in contrast to Hillyard and Dombrink’s analysis of the two campaigns, that the Catholic Church’s rhetoric during the 1994 campaign was almost entirely dominated by moral and religious arguments; the Church’s strategy in 1997, in contrast, was much more secular, emphasizing terminally ill misdiagnoses and clinical failures over the sins of suicide. Finally, the present relevance of the recent developments in health care reform call for a reassessment of the meaning and significance of the 1994 and 1997 debates surrounding PAS.

BACKGROUND TO THE OREGON DEATH WITH DIGNITY ACT

The legalization of PAS in Oregon arose from a growing dissatisfaction with the medical profession and the development of a national “right to die” movement. The 1994 legalization of PAS in Oregon illustrated the erosion in deference to the medical establishment that culminated in the 1960s and 1970s. Patients had become increasingly concerned about the distance between doctors and patients, the repercussions of modern medicine on patient care, and the tendency for doctors to act simply as technicians and lose sight of the patient as a person. Americans were seeking to regain control of their own bodies and take health care into their own hands by questioning the authority of the medical profession [5].

1 For a discussion on the importance of the doctor-patient relationship and the principle of autonomy in 20th-century bioethics, see Chapter 6 of Renée C. Fox and Judith P. Swazey’s Observing Bioethics (Oxford: Oxford University Press, 2008). This work also contains interviews with prominent bioethicists Robert Veatch, Ruth Macklin, and Daniel Callahan, who describe the influence of the civil rights and women’s liberation movement on patients’ rights, autonomy, and anti-paternalism in the 1960s and 1970s. See also Carla Messikomer, Renée Fox, and Judith Swazey, “The Presence and Influence of Religion in American Bioethics,” Perspectives in Biology and Medicine, 2001;44(4):491-2; Daniel Callahan, “Universalism and Particularism: Fighting to a Draw,” Hastings Center Report, 2000;30(1):40; and James T. Patterson, “Disease in the History of Medicine and Public Health,” in Major Problems in the History of American Medicine and Public Health, eds. John Harley Warner and Janet A. Tighe (Boston: Houghton Mifflin Company, 2001), p. 20-1.
describes, “[i]n these years, the exalted, near-priestly reputations of white-coated medical personnel dropped precipitously” [6]. The “right to die” sentiment developed in parallel with this skepticism of medical authority, beginning in 1967 with the creation of the first living will that allowed patients to control decisions about their end-of-life care years in advance [7].

By the mid-1970s, every state in the nation had decriminalized suicide, and a large number of states simultaneously affirmed that withholding or withdrawing life-sustaining treatment was not suicide. The 1976 case of In Re Quinlan was the first to consider “right to die” claims based on the right to privacy. In this case, the father of a 22-year-old woman in a persistent vegetative state petitioned the New Jersey Supreme Court with a request to withdraw her respirator. Concerning the decision to allow withdrawal of treatment, author Raymond Whiting explains that the New Jersey Supreme Court “elected . . . to set the standard for all ‘right to die’ cases by basing its decision to allow the removal of the respirator on Ms. Quinlan’s right to privacy” [8]. Further legislation in the 1980s and early 1990s recognizing a right to die spurred a sudden increase in the number of articles in professional journals discussing this right, as well as the formation of national right to die organizations [9].²

In addition to the national preoccupation with the right to die, the political and social culture of the state of Oregon fostered a unique environment for the eventual success of PAS legalization. Oregon has a history of anti-authoritarian decision-making in the field of health care. During the Progressive Era, citizens of Portland led a vociferous campaign against compulsory vaccination. Residents denounced government interference in health care and criticized the medical professionals who touted their medical expertise as more valid than parents’ wishes [10]. More recently, in 1989, Oregon embraced a progressive health care reform bill — the first of its kind in the nation — that extended medical care to more lower-income families currently not covered by the state’s insurance [11-12].³ Oregon’s independent mindset in the field of health care is likely rooted in the state’s early history; as Brian Doyle of the University of Portland, Oregon, describes, “Oregon was a determinedly independent territory, fending off the national claims of Britain, Russia, and Spain, before it ever became one of the American States” [13].

Support for the right to die was especially high in Oregon, and nearly 60 percent of Oregon citizens polled expressed support for legalizing PAS, which would allow doctors to prescribe lethal medication to terminally ill patients who would then self-administer it [14]. In 1994, a group known as Oregon Right to Die, along with other euthanasia and PAS activists, proposed a ballot initiative in Oregon — Measure 16, or the Oregon Death with Dignity Act — that would allow physicians to prescribe lethal drugs to terminally ill patients who met specific clinical criteria.⁴ Though attempts at legalizing PAS had failed earlier in California and Washington, Oregon had a distinctive political and social climate that made the legalization of PAS more likely to succeed.⁵

²Although support for the right to refuse or withdraw medical treatment had become widespread by the 1970s, many philosophers and health care professionals remained opposed to aid-in-dying. See Daniel Callahan, “When Self-Determination Runs Amok,” Hastings Center Report, 1992;22(2):52-5.

³See also Jonathan Oberlander, “Rationing Medical Care: Rhetoric and Reality in the Oregon Health Plan,” Canadian Medical Association Journal, 2001;164(11):1583-7 for details of the plan and its importance for national public policy.

⁴For a criticism of the frequent use of the term “dignity” in bioethics, see Ruth Macklin, “Dignity is a Useless Concept,” British Medical Journal, 2003;327:1419-20.

⁵The initiatives that failed were Washington’s initiative 119 and the California Proposition 161, defeated in 1991 and 1992, respectively. See Brian Doyle, “Killing Yourself: Physician-Assisted Suicide in Oregon,” in American Catholics, American Culture: Tradition & Resistance, ed. Margaret O’Brien Steinfels (Oxford: Sheed & Ward, 2004), p. 78.
Oregon was a “unique state both in terms of the long history of citizens using the initiative power as a tool of legal and social change and in terms of citizens’ defiance toward both organized religion and outside political pressure” [15]. Oregon was the first U.S. state to implement the citizen’s initiative process, which authorized petitions signed by a minimum number of Oregon voters to force a public vote or persuade lawmakers [15-16]. Progressive Era Portland, Oregon, also has been described as “the primary social base of the ‘Oregon System’ of direct legislation . . . [and] the center of the national movement for direct democracy” [17].

THE 1994 OREGON DEATH WITH DIGNITY ACT CAMPAIGN

The 1994 Oregon Death with Dignity Act, or Measure 16, was a citizens’ initiative led by Barbara Coombs Lee, a nurse, lawyer, and the Chief Petitioner of Measure 16, and Dr. Peter Goodwin, a family practitioner and professor who drafted the measure. The Act would permit adult Oregon residents, who had voluntarily expressed the wish to die, to “make a written request for medication for the purpose of ending his or her life in a humane and dignified manner” [18]. The patient’s attending physician was required to fulfill a list of responsibilities, including the initial determination of a terminal illness, and had to consult a second physician to confirm the terminal diagnosis [18].

Coombs Lee had experience in both nursing and law and spent much of her nursing career caring for terminally ill patients. Dr. Goodwin was an associate professor of family medicine at Oregon Health Sciences University School of Medicine, Portland, who became interested in advocating for PAS after the deaths of several of his patients [19]. Dr. Goodwin also served as the board director for the Hemlock Society, a prominent right-to-die organization that promoted both PAS and voluntary euthanasia [20-21]. Together with a new group, Oregon Right to Die, and campaign strategist Eli Stutsman, Coombs Lee and Dr. Goodwin set out to propose a citizens’ initiative that would seek to legalize physician-assisted suicide. In both 1994 and 1997, Coombs Lee, Stutsman, and Dr. Goodwin were the primary figures responsible for shaping the campaign to legalize PAS [21].

Coombs Lee, Dr. Goodwin, and Oregon Right to Die marketed Measure 16 by appealing to Oregon citizens’ individual self-determination, desire for choice, and patient autonomy at the time of death. Dr. Goodwin emphasized that patients would be “empowered” by the fact that PAS legislation would allow them more control over decisions during death [22]. Other proponents argued that patients had a right to choose the timing and manner of their deaths when faced with a terminal illness, rather than having to suffer an undignified, possibly humiliating, and likely painful death. A 1994 op-ed article from The New York Times entitled “A Rational Right” described a reader’s understanding that “[i]n a rational democracy competent individuals should be

Consulting physicians were also required to refer the patient to counseling if a mental disorder was suspected. For discussions about competency and the ability of terminally ill patients to consent to PAS, see Linda Ganzini et al., “Evaluation of Competence to Consent to Assisted Suicide: Views of Forensic Psychiatrists,” American Journal of Psychiatry, 2000;157(4): 595-600; Margaret A. Drickamer et al., “Practical Issues in Physician-Assisted Suicide,” Annals of Internal Medicine, 1997;126(2): 147-8; and Cameron Stewart et al., “A Test for Mental Capacity to Request Assisted Suicide,” Journal of Medical Ethics, 2011;37(1): 34-9. For an argument that suicide can never be a “rational” act, see Joseph Richard, “The Case against Rational Suicide,” Suicide and Life-Threatening Behavior, 1988;8(3):285-9.

For a defense of PAS as upholding autonomy, see Ronald Dworkin, Life’s Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom (New York: Vintage Books, 1994).

For a theological perspective on assisted suicide and the relief of suffering, see Karen Lebacqz, “Reflection,” in On Moral Medicine: Theological Perspectives in Medical Ethics, ed. Stephen E. Lammers and Allen Verhey, 2nd ed (1998), p. 666. See also John Rawls, et al., “Assisted Suicide: The Philosopher’s Brief,” in Philosophy and Death: Introductory Readings, ed. Samantha Brennan and Robert J. Stainton (Toronto: Broadview Press, 2010), p. 331-44.
in control of their own lives. . . . This logically includes the manner of dying” [23]. The author argued that Measure 16 protected an individual’s rights while still respecting those of the community. Measure 16 supporters tried to depict the legalization of PAS as a right that upheld patients’ choice, control, and freedom at the end of life.

Proponents of Measure 16 also realized the power of individual anecdotes to sway public perception. These anecdotes added a sympathetic, personal dimension to a procedure that was often portrayed by opponents as malicious or impersonal. Proponents used individual testimonies from both prominent medical professionals and patients and their families who supported PAS. In a 1995 interview with Hospitals & Health Networks, Dr. Goodwin explained that he became a PAS activist after witnessing the suffering of a former patient diagnosed with pancreatic cancer. His patient “died a horrible death, coughing his lungs out and vomiting his life away. It shouldn’t have to be that way” [24].

Anecdotes had become a commonly used tool to appeal emotionally to voters. One 60-second television ad in support of Measure 16 featured former nurse Patty A. Rosen of Bend, Oregon, who told her story about seeking drugs illegally to help her daughter die:

“I am a criminal,” Rosen says. “My 25-year old daughter, Jody, was dying of bone cancer. The pain was so great that she couldn’t bear to be touched, and drugs didn’t help . . . she decided she wanted to end her life. . . . So I broke the law and got her the pills necessary. And as she slipped peacefully away, I climbed into her bed and I took her in my arms (Rosen’s voice cracks with emotion) for the first time in months” [25].

The ad continues with Rosen urging voters to vote “yes” on Measure 16 and to uphold the right to die a dignified death. In actuality, Rosen had revealed in a 1992 talk to the Hemlock Society that the lethal medication she gave to her daughter had not ensured a clean, efficient, or “peaceful” death. Out of fear that her daughter would eventually wake up, Rosen was forced to inject her with morphine and give her a suppository to prevent her from vomiting the lethal pills [25-27]. The message portrayed on television by Measure 16 supporters, however, was that PAS did work, and that the procedure was simple, dignified, and merciful. Ironically, PAS supporters, while advocating for increased patient autonomy at the end of life, relied on the cultural authority of high-tech medicine to claim that PAS was clean, safe, and medically effective. 10

In addition to personal anecdotes, rhetoric directed against religious groups and the Catholic Church was used to persuade voters to support PAS legalization. With only 12 percent of the Oregon population identified as Catholic and considerable public sentiment against religious political involvement, Measure 16 supporters knew they could draw on hostility toward the Catholic Church to mobilize their campaign efforts [28].

For a similar philosophical argument, see Tom Beauchamp and James Childress, Principles of Biomedical Ethics (New York: Oxford University Press, 1979), p. 90.

While most physicians would use oral barbiturates, benzodiazepines, and narcotics to aid in a patient’s death (see Margaret A. Drickamer et al., “Practical Issues in Physician-Assisted Suicide,” Annals of Internal Medicine, 1997;126(2):149-50), there was no true consensus among physicians as to which lethal medications to prescribe. A 1996 study in the New England Journal of Medicine reported that 50 percent of physicians surveyed in Oregon “were not sure what they would prescribe if they decided to comply with a patient’s request for a lethal dose of medication.” See Melinda A. Lee et al., “Legalizing Assisted Suicide—Views of Physicians in Oregon,” New England Journal of Medicine, 1996;334(5):313.

Brian Doyle of the University of Portland, Oregon, attributes Oregonians’ distaste for Catholicism to political developments in the 1920s. Oregonians passed a measure in 1922 banning private education, and the Catholic university led a tumultuous 3-year fight to overturn the law. See Brian Doyle, “Killing Yourself: Physician-Assisted Suicide in Oregon,” in American Catholics, American Culture: Tradition & Resistance, ed. Margaret O’Brien Steinfels (Oxford: Sheed & Ward, 2004), pp. 77, and M. Paul Holsinger, “The Oregon School Bill Controversy, 1922-1925,” Pacific Historical Review, 1968;37(3):327-41.
nents realized that many Oregonians were particularly antagonistic toward the Catholic Church during the 1994 election season because the Church had endorsed a controversial measure on the same ballot as Measure 16 that would have prevented state anti-discrimination laws protecting homosexuals [29]. As an article in The Christian Century lamented, the Church’s endorsement of the anti-gay measure “aroused enough anger against the Catholic political machinery that some voters vowed to vote against the Church on every initiative regardless of its own merits” [30-31]. Moreover, since Oregon had only a small percentage of Catholics in the state, most Oregon voters saw the Catholic Church’s involvement against Measure 16 as an attempt by organized religion to impose its views on the public. 12

Campaign television ads commonly attacked the Catholic Church’s active role in politics. One such ad, “Faces,” showed a series of adult faces while a voice told listeners: “I don’t need any church playing politics with my choices, with my life” and “Measure 16 . . . ends . . . religious interference in a part of our lives that is strictly personal” [32]. Other radio ads supported by Oregon Right to Die argued that groups campaigning against PAS felt a “divine right” to interfere with other people’s lives and choices [33-34].

Despite the small minority of Catholic voters in Oregon, the Catholic Church decided to launch a $1.5 million campaign against Measure 16 [32,35]. 13 The Church hoped that by emphasizing the moral and ethical problems with PAS, they could mobilize Oregon voters to consider whether Measure 16 was truly guaranteeing patients a “dignified death,” as its proponents claimed. In the 1994 campaign, the Catholic Church aggressively emphasized the moral and religious problems with PAS to its Church members. 14 Although the Coalition for Compassionate Care also sponsored several television advertisements raising the possibility of terminally ill misdiagnoses and depression motivating requests for assistance in suicide [36], the Catholic Church’s 1994 campaign against Measure 16 was primarily aimed at reminding Catholic Oregonians of the ethical implications of PAS.

The Church used its pulpits to urge Catholics to vote against Measure 16 and make a political contribution to the Coalition for Compassionate Care [37]. For example, Archbishop William J. Levada of the Diocese of Portland and Bishop Thomas J. Connolly of the Diocese of Baker urged priests around the state to preach against PAS on September 18, 1994, and to collect in-pew donations the following Sunday. The Church explained that on September 18, Catholic churches statewide would hold a special “Mass of Compassionate Care for the Dying” to emphasize the sanctity of old

12 For a discussion on Catholicism in Oregon, see Brian Doyle, “Killing Yourself: Physician-Assisted Suicide in Oregon,” in American Catholics, American Culture: Tradition & Resistance, ed. Margaret O’Brien Steinfels (Oxford: Sheed & Ward, 2004), p. 76-8.

13 To clarify, by “Catholic Church” I refer to the bishops and clerical political councils that opposed the Oregon Death With Dignity Act, such as the Northwest bishops, the California Catholic Conference, Archbishop William Levada, and Bishop Thomas Connolly of Oregon. Oregonian lay Catholics likely took a variety of stances on the issue. Bishops and clerical councils primarily interacted with society through advertising campaigns (especially during the 1997 campaign), sermons denouncing PAS, and requests for financial contributions from Oregon’s registered Catholics and congregants. For more on the complex nature of Catholicism in Oregon during the 1994 and 1997 campaigns, see Brian Doyle, “Killing Yourself: Physician-Assisted Suicide in Oregon,” in American Catholics, American Culture: Tradition & Resistance, ed. Margaret O’Brien Steinfels (Oxford: Sheed & Ward, 2004), p. 76-101.

14 For prominent Catholic theological viewpoints on assisted suicide, see St. Thomas Aquinas, “Whether It Is Lawful to Kill Oneself,” in Ethical Issues in Death and Dying, ed. Tom L. Beauchamp and Robert M. Veatch, 2nd ed. (New Jersey: Prentice Hall, 1996), p. 119-21, and John Paul II, “Euthanasia,” in On Moral Medicine: Theological Perspectives in Medical Ethics, ed. Stephen E. Lamers and Allen Verhey, 2nd ed (Grand Rapids: William B. Eerdmans Publishing, 1998), p. 650-4.
Despite the Catholic Church’s efforts against PAS legalization, Measure 16 passed with 51 percent of the vote. After a legal injunction and several court cases, the Act finally became law on October 27, 1997. After this defeat, Catholic organizations and Right to Life campaigners — including a new partner, the National Right to Life Committee — convinced the Oregon Medical Association (OMA) to join the effort to repeal Measure 16. The organization was under new leadership by this time, and the Catholic Church had successfully urged the OMA to reconsider its earlier neutral stance [41]. With support from the OMA, the Catholic Church exhorted the Oregon legislature to give voters a chance to repeal the law. In 1997, the Oregon legislature agreed to place a measure (Measure 51) on the general election ballot in November that would allow voters to repeal the Act just 3 years after the initial vote.

Supporters of PAS, including Coombs Lee, Dr. Goodwin, and Oregon Right to Die, were forced to mobilize voters’ support again to uphold the 1994 law. The campaign against repeal of the Act was led by the same pro-PAS groups from the 1994 campaign, and campaign leaders re-used successful media techniques from the 1994 campaign such as individual testimonies and anti-Catholic rhetoric. For example, Measure 51 opponents featured testimony from Dorothy Hoogstraat, the wife of a prostate cancer patient Emerson Hoogstraat:

My husband, Emerson, had terminal cancer. But politicians took away any chance he had to use measure 16. He died a horrible death. . . . The choice about using Measure 16 was taken away from Emerson. Don’t let them take that choice away from you [42].

In the “Measure 51 Arguments in Opposition” packet published by the Oregon Secretary of State Elections Division, Hoogstraat described her husband’s painful death, despite increasing doses of morphine, and told voters that Emerson could have been spared months of agony if the Death with Dignity Act had been available to him [1]. Once again, personal testimony was mobilized to argue in favor of legalizing PAS. In the third of a series of “Measure 51 Doctor-Assisted Suicide Voter’s Guide” articles in The Oregonian, Tricia Knoll of Portland, Oregon, told readers that she wished PAS had been made available to her mother. Knoll described her mother’s wish to commit suicide after enduring weeks of pain from ovarian cancer and informed readers that “I bitterly resent . . . that she did not have the choice — because the choice is exactly what she asked for” [43]. Individual testimonies from surviving family members of patients who died painful deaths highlighted the individual impact of PAS legislation and played on voters’ possible experiences with painful or undignified deaths of friends or family members.

Again, Measure 51 opponents used familiar rhetoric lamenting the role of the Catholic Church and organized religion in politics to urge voters to vote against repeal. A television ad sponsored by the repeal opponents warned that “[t]he Catholic Church is spending a fortune to repeal Measure 16.
They want to impose their views on the rest of us” [44]. A set of radio ads sponsored by the “Don’t Let ’Em Shove Their Religion Down Your Throat Committee” warned against religious politicians’ attempts to impose their beliefs on the public. One Oregon voter described to The Oregonian his disapproval of the Catholic Church’s political role: “Religion is fine . . . [b]elieve what you want to believe. But I liked the slogan of the committee running those ads: ‘Don’t shove your religion down my throat!’” [31,44,45]. Voters also expressed their disillusionment with the Catholic Church and religion more generally in the “Measure 51 Arguments in Opposition” packet, urging other voters to keep religion and politics separate and specifically to keep religious political machines out of end-of-life decisions [46]. With the Catholic Church’s continued involvement in the repeal of PAS legislation, Measure 51 opponents used anti-Catholic media techniques that had proven successful in the 1994 PAS campaign.

Measure 51 opponents also capitalized on an angle unique to the 1997 campaign against repeal: harnessing voters’ anger toward the legislature. Many voters were furious that the Oregon legislature would sway to political and religious pressures and refer Measure 16 back to the ballot when the public had already decided on the issue 3 years before. Polls revealed that up to 66 percent of voters would not vote to re-elect legislators who mandated second votes [47]. Coombs Lee realized early on how she could use voters’ anger with the Oregon legislature in the 1997 campaign and perhaps motivate voters to vote “no” on the repeal even if they had not supported PAS in 1994 [48]. One anti-51 campaign television ad showed Dr. Glen Gordon, a former president of the OMA, denouncing politicians’ roles in PAS:

> Sometimes my patients and their families have to make very difficult choices about life and death. When we passed Measure 16, we guaranteed that all patients would have a choice. But now some politicians in Salem are making us vote on this all over again. Measure 16 has every safeguard patients and doctors could want. Now all we need is protection: from the politicians [49].

Coombs Lee and members of other component groups of the anti-51 campaign also sponsored arguments in the “Measure 51 Arguments in Opposition” voters’ packet, emphasizing that the Oregon legislature had ignored the will of Oregon voters.

Oregon citizens responded strongly to cries against the Oregon legislature’s abuse of power. One Portland man asked readers of The Oregonian “why have we allowed our legislators to tell us we were mistaken the first time and that we must vote again on the same issue with Measure 51?” [50]. He then went on to call the legislature a “chiding parent” and accused politicians of being “smug moralists” [50].

Leaders of the Catholic Church, extremely pleased with the Oregon legislature’s agreement to send the Act back to the public for a second vote, realized early on that they would have to steer clear of religious arguments to get votes. Catholic leaders understood from the anti-Catholic backlash of the 1994 campaign that they would have to stay away from the religious and moral arguments that dominated previous efforts. Auxiliary Bishop Kenneth Steiner told The Oregonian that the Catholic Church “stayed in the background. . . . We didn’t want this to backfire on us as it did in 1994, when they said this is the Catholic Church, or the religious right, or religious extremists, or conservatives” [51]. This is not to say, however, that the Church neglected to remind its Catholic members of the religious and moral implications of allowing PAS to continue. In 1996, the ailing Roman Catholic Archbishop of Chicago urged Oregonians to vote against PAS as one of his final wishes before death. The Cardinal argued that PAS constituted a “direct attack on innocent human life” [52]. In the same year, Cardinal O’Connor, the Roman Catholic Archbishop of New York, delivered warnings in his Easter Mass that
legalizing PAS could threaten marginalized members of society [53].\textsuperscript{15} The Church understood, however, that to convince most Oregon voters to repeal PAS, it would have to focus purely on the medical and clinical problems associated with Measure 16.

To persuade Oregon voters that the Oregon PAS statute was flawed, the pro-repeal campaigners appealed to recent research studies conducted in the Netherlands that proponents claimed demonstrated a 25 percent failure rate with PAS—a statistic that received national attention when it was cited in a \textit{New York Times} op-ed by Derek Humphry, founder of the Hemlock Society USA [54].\textsuperscript{16} Humphry explained that the only way the Oregon law could work clinically would be if a doctor could administer the “coup de grace” if the assisted suicide attempt failed (meaning the patient vomited up the medication, fell into a coma, or was unable to finish taking the lethal pills). He told readers that a patient’s only other choice was to suffocate him or herself with a plastic bag to hasten death [54]. Though Humphry intended the article as an argument for extending Oregon’s law to include euthanasia, proponents of Measure 51 latched on to his statistics to prove to voters the clinical problems with Measure 16.

Pro-repeal commercials sought to convince voters of the clinical failures inherent to PAS through television commercials and local protests. In one television commercial that came to be known simply as the “Billy” ad, a healthy-looking young man, ‘Billy,’ enters a waiting room and awaits his doom. “Three weeks ago, Billy was told that he had less than six months to live. And in 15 minutes, a doctor is going to give him a lethal prescription—just to make sure,” the narrator intones. “But what Billy doesn’t know is that he won’t die right away. He’ll choke on his own vomit, in painful convulsions, and linger for days” [44,47,55].

The ad repeated concerns raised in Humphrey’s op-ed and added graphic descriptions of the suffering that a patient could endure if the suicide attempt failed. Pro-repeal Oregon voters also used dramatic grassroots efforts to demonstrate the possible clinical failures that could result from Measure 16. One Oregon woman and former psychologist drove a minivan through Portland suburbs with a large plastic bag (among other anti-PAS props). She told reporters “[i]f the pills worked all the time, why is Derek Humphry telling people to buy a turkey bag?” [44]. From efforts at the grassroots level to statements from pro-life doctors warning of “turkey bags and bungee cords,” the pro-repeal campaigners used the images and statistics indicative of PAS fail-

\textsuperscript{15}All available evidence from the Oregon PAS program since its inception in 1998 suggests that patients who choose PAS are not from marginalized social groups. A 2009 summary of the Oregon program revealed that 98.3 percent of participants were white, 48.3 percent of participants had a bachelor’s degree or more, and 98.7 percent of patients had some type of health insurance (see “2009 Summary of Oregon’s Death with Dignity Act,” Oregon Department of Human Services (March 2010), available from http://www.oregon.gov/DHS/ph/pas/docs/year12.pdf.) These statistics suggest that racial minorities do not tend to use PAS services and that those patients who do are educated and arguably less susceptible to coercion or abuse. While the summary report did not publish the socioeconomic statuses of the patients, these numbers indicate that most were from more affluent backgrounds. One British report found that participants in the Oregon program tend to be “pragmatic, matter-of-fact persons who have always been in control of their lives … and want to name the day … when they are finished, when life has served them, and enough is enough” (see “Chapter 5: Overseas Experience,” First Report (Select Committee on Assisted Dying for the Terminally Ill Bill, 2005), p. 163, accessed December 2, 2010, available from http://www.publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/8608.htm).

\textsuperscript{16}For the original study, see Groenewoud JH, et al., “Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands,” \textit{New England Journal of Medicine}, 2000;342: 551-6. For a criticism of Groenewoud’s findings, see Peter A. Rasmussen, “Correspondence: Physician Assisted Suicide and Euthanasia,” \textit{New England Journal of Medicine}, 2000;343:150.
ure to convince voters that Measure 16 as it stood did not ensure a dignified death [48].

Pro-repeal campaigners also argued that Measure 16’s requirement that a PAS patient be diagnosed as terminally ill was not an adequate safeguard due to the possibility of medical misdiagnoses. In the final words of the “Billy” advertisement, for example, the narrator tells viewers that “Billy isn’t terminal. His diagnosis was wrong” [44]. Proponents of repeal used personal testimonies of patients diagnosed as terminally ill who then went on to live days, months, or even become completely healed. In a special “Voters’ Guide” section of The Oregonian, an Oregon woman described her father’s death from cancer. She explained that one day during her father’s illness, which was deemed terminal, her father rose from the bed filled with energy and laughter and walked into the family room to share stories with her and other family members. Choosing PAS, she argued, would have denied her family those last moments of joy with her father [43].

Pro-repeal television ads demonstrated to viewers the risks of terminally ill misdiagnoses. One television ad featured an Oregon woman, Lois Riddle, and her daughter, Sarah, who told viewers that her mother was once very ill and now lives a full and healthy life. “Yes on 51” campaign manager Trish Conrad explained that the “point of the ad . . . is to show that because doctors make mistakes, loved ones might die unnecessarily” [55]. A second series of television ads featured an Oregon psychiatrist who told viewers how depression is difficult to diagnose in patients and that it could be challenging to conclude how much time terminally ill patients have left to live [55].

Despite the Catholic Church’s efforts to convince voters of the clinical failures and risk of misdiagnosis associated with PAS, the repeal effort was unsuccessful. Oregonians ultimately decided to uphold PAS with 60 percent of the vote [56]. Measure 51 opponents had successfully mobilized voter frustration over the Oregon legislature sending the PAS measure back to the public for a second vote. By promoting anti-politician messages, Measure 51 opponents were able to distract voters from the Catholic Church’s reports of clinical failures and terminally ill misdiagnoses accompanying PAS [57].

CONCLUSION AND OUTLOOK

The 1994 legalization of physician-assisted suicide in Oregon arose from a growing lack of deference to medical authority, emphasis on patient autonomy, and increasing support of patients’ right to die. Oregon was a prime location for the first physician-assisted suicide law, with a progressive political history, a recent statewide health care reform bill, and a population wary of religious political influence. During the 1994 and 1997 physician-assisted suicide campaigns, organizations that supported physician-assisted suicide appealed to voters’ desires for patient choice and control and exploited anti-Catholic sentiment. Religious organizations that opposed the Act, such as the Catholic Church, responded by mobilizing Church members and reminding voters of the religious and moral implications of physician-assisted suicide.

Ultimately, the public discussion surrounding the 1994 Oregon Death With Dignity Act resolved very little in the ongoing debate over how to properly balance patient autonomy, physician authority, and dignity at the end of life.” After the legalization of

17For more on the concern about medical misdiagnosis and the difficulty of accurately diagnosing a patient as terminally ill, see Margaret A. Drickamer et al., “Practical Issues in Physician-Assisted Suicide,” Annals of Internal Medicine, 1997;126(2):148-9, and Melinda A. Lee et al., “Legalizing Assisted Suicide—Views of Physicians in Oregon,” New England Journal of Medicine, 1996;334(5):313, 315.

18For more on the principle of autonomy, see James F. Childress, “The Place of Autonomy in Bioethics,” The Hastings Center Report, 1990;20(1):12-17, and Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics, 5th ed. (Oxford: Oxford University Press, 2001). Some philosophers argue that PAS may actually undermine personal autonomy by placing what is typically a private event (death) in the hands of medical practitioners. See Tania Salem, “Physician-Assisted Suicide: Promoting Autonomy—Or Medicalizing Suicide?” The Hastings Center Report, 1999;29(3):33-6.
physician-assisted suicide in Oregon, similar debates took place in several U.S. states. In 2008, Washington State followed in Oregon’s footsteps and legalized physician-assisted suicide through a citizens’ initiative [58]. A year later, the Montana Supreme Court held that physician-assisted suicide did not violate public policy and that doctors who helped patients commit suicide could not be prosecuted [58].

The debates present in the 1994 and 1997 campaigns served as a template for what would eventually become a nationwide conflict. Concerns over physician authority and the doctor-patient relationship have continued to shape current public discussions about end-of-life care and public health policy. 19 Rhetoric and themes from the Oregon physician-assisted suicide campaigns would arise in discussions of national health care reform under the Obama administration. For example, opponents of physician-assisted suicide criticized the 1994 Measure 16 as “open to abuse because it . . . leaves those without access to good health care vulnerable to facing suicide as the least costly treatment option” [59].

Similarly, politicians opposed to President Obama’s health care reform invoked fears of “death panels” that would cave in to economic pressures and choose a patient’s death rather than continuing treatment. 21 The term “death panel” was first coined by Sarah Palin on August 7, 2009, on a Facebook posting, in which Palin criticized President Obama’s proposed America’s Affordable Health Choices Act of 2009 (HR 3200): “[t]he America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama’s ‘death panel’ so his bureaucrats can decide . . . whether they are worthy of health care” [60]. Palin was criticizing a section of the Affordable Health Choices Act that would make voluntary end-of-life care discussions, or “advance care planning,” reimbursable for Medicare patients [61].

The Catholic clergy lauded President Obama’s desire to provide health care coverage for America’s uninsured populations [62], but several outspoken Catholic leaders confirmed Palin’s fear that the advanced care planning section of the Act might “encourage our elderly to take their own lives rather

19 For more on the doctor-patient relationship, see Thomas L. Delbanco, “Enriching the Doctor-Patient Relationship by Inviting the Patient’s Perspective," Annals of Internal Medicine, 1992;116(5):414-8. Some philosophers fear that legalizing PAS would change the role of the physician toward her patient; see Leon Kass, “Neither for Love Nor Money: Why Doctors Must Not Kill," Public Interest, 1989;94:25-46; Margaret A. Drickamer et al., “Practical Issues in Physician-Assisted Suicide," Annals of Internal Medicine, 1997;126(2):148; and Lois Snyder et al., “Physician-Assisted Suicide," Annals of Internal Medicine, 2001;135(3):212-4. Ezekiel Emanuel and Linda Emanuel describe four models of the doctor-patient relationship, and the shift from a paternalistic model toward an informative model, in which “physicians are described as health care providers and patients as consumers." See Ezekiel Emanuel and Linda Emanuel, “Four Models of the Physician-Patient Relationship," Journal of the American Medical Association, 1992;267(16):2223.

20 Fears that assisted suicide and medical rationing could lead to abuse of the terminally ill are not new; see Richard A. McCormick, “Physician-Assisted Suicide: Flight from Compassion," Christ Century, 1991;108(35):1132-4.

21 The 1994 and 1997 campaigns revealed a historical concern with the rationing of medical care that had been raised as early as the 1960s. In 1962, LIFE Magazine published an article discussing a panel at Seattle’s Swedish Hospital responsible for selecting kidney dialysis patients for a limited number of dialysis machines. The panel, which the LIFE article terms the “Life or Death Committee," was forced to choose one dialysis recipient for every 50 eligible patients. As the author describes, the panel "must decide, in the words of the ancient Hebrew prayer, 'Who shall live and who shall die.'" Similar fears about physicians or panels deciding when a patient should die were raised under President Clinton’s 1993 health care proposal by Betsy McAughey, former lieutenant governor of New York, the American Spectator magazine, and the Washington Times. See Shana Alexander, “They Decide Who Lives, Who Dies," LIFE Magazine, Nov. 9, 1962, available from http://kidneytimes.com/article.php?id=20110304143111, and Jim Rutenberg and Jackie Calmes, “False ‘Death Panel’ Rumor Has Some Familiar Roots," The New York Times, Aug. 13, 2009, accessed Nov. 25, 2011, available from http://www.nytimes.com/2009/08/14/health/policy/14panel.html.
than somehow become a ‘drain’ on the rest of us” [63]. Deacon Keith Fournier of the Diocese of Richmond, Virginia, argued that the section of the Act requiring end-of-life counseling reimbursement was closely linked to other sections mandating coverage for contraception — leaving Obama’s plan “fatally infected with the ideology of the culture of death at both ends of life” [63-64]. The United States Conference of Catholic Bishops (USCCB) reiterated its support for comprehensive health insurance, while reminding Congress that “we strongly oppose . . . inclusion of technologies that . . . fail to uphold the sanctity and dignity of life. No health care reform plan should compel us or others to pay for the destruction of human life” [65].

The Obama administration responded to religious and conservative political criticism with appeals to patient autonomy familiar to the Oregon physician-assisted suicide campaigns. One professor cited by the administration explained that “end-of-life discussions between doctor and patient help ensure that one gets the care one wants . . . [and] protect patient autonomy” [66]. Physician groups, including the American College of Physicians and the American Academy of Family Physicians, also spoke out in support of the regulation, emphasizing that advance care planning protected patient’s wishes at the end of life [67]. Some physicians even used personal anecdotes to marshal support for reimbursement of end-of-life care discussions. In the *Annals of Internal Medicine*, Dr. Meltem Zeytinoglu told of his mother’s experience of making end-of-life treatment decisions during the final stages of terminal breast cancer. He argued that discussions early on about treatment options could have made his mother’s final moments more comfortable, and that these conversations “empower [patients] with the information they need to make the decisions that are best for them” [68]. Despite these efforts, conservative opponents of health care reform continued to use the phrase “death panels” after Palin coined the term, in what bioethicist George J. Annas deems “a rhetorical device to block any rational discussion of either death generally or end of life care in particular” [69]. Ultimately, Obama’s Patient Protection and Affordable Care Act, a similar bill that was eventually signed into law in 2010, left out the advance care planning reimbursement requirement for fear of political backlash [70].

Whether the policy in question is aid-in-dying or changes to health insurance systems, national concerns with the doctor-patient relationship, patient autonomy, medical authority, and potential for patient abuse continue to play formative roles in American discussions about health care. The conflict in Oregon marked the beginning of the now nationwide problem of determining if and when a terminally ill person can choose to die.

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