TO SUCCEED OR NOT TO SUCCEED: HOW DO POLITICAL INFLUENCES, CULTURE, AND DEMOGRAPHICS OF A STATE AFFECT THE PASSING OF PHYSICIAN ASSISTED SUICIDE INITIATIVES?

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DISSERTATION ABSTRACT

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Today, many physicians are concerned with how to properly care for patients with terminal illnesses and unbearable pain. In deciding the best care possible, ethical and moral concerns have become an issue. Many feel patients should have more autonomy when making decisions regarding their care, but this expansion of autonomy has caused conflict. This conflict has encouraged new conversations on ethics as well as initiated new legislation and court cases to resolve these conflicts. Currently in the United States, with the exception of Oregon, helping another person commit suicide is a crime. In 1997, through an initiative, Oregon started allowing people who are terminally ill to obtain a lethal prescription from their physician to end their life. There have been four failed ballot initiatives between 1991 and 2000. In 1991, Washington citizens introduced Initiative 119 which was defeated by a vote of 54% to 46%. In 1992, California citizens introduced Proposition 161 which was defeated by a vote of 54% to 46%. In 1998, Michigan citizens introduced Proposal B which was defeated by a vote of 71% to 29%. In 2000, Maine citizens introduced Maine's Death with Dignity Act which was defeated by a vote of 51% to 49%. This research analyzed the five states' efforts to legalize physician assisted suicide to determine what factors affected the outcome of these initiatives. The research answered the question, what factors contributed to Oregon's success and the defeat of the initiative in Washington, California, Michigan, and Maine? Six factors of each state were analyzed to answer this question which included governor influence, interest group influence, political culture, religion, age, and gender. The results concluded that governors, interest groups, religion, age, and gender affected the outcomes of these initiatives. A chi square analysis conducted on exit poll data from California, Oregon, and Michigan found that age and gender were statistically associated with physician assisted suicide whereas religion was not. Other factors may have also influenced the initiative outcomes. In Washington and Michigan, Jack Kevorkian's killings may have adversely affected how citizens viewed PAS. In Oregon, a mother's poignant testimony about helping her daughter die with pills may have influenced Oregon's success, and in all five of the states, ad campaigns challenged citizens to think about the ramifications of legalizing physician assisted suicide and how their lives would be forever affected if physician assisted suicide was legalized in each of the five states.

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CHAPTER 1: INTRODUCTION

Many citizens and interest groups support the legalization of physician assisted suicide, yet most states have deemed the practice illegal. A March 1999 poll conducted by Gallup showed that 61% of Americans believed that physician assisted suicide should be legal. This number had decreased from 75% according to a poll conducted by *USA Today* in May 1996. As a result of citizens' belief that physician assisted suicide should be legalized, supporters of the practice have initiated ballot proposals to legalize the practice in Washington, California, Oregon, Michigan, and Maine. However, only Oregon approved the initiative. The other states rejected it.

According to a story in the *Oregonian* on November 10, 1994, the Roman Catholic Church called physician assisted suicide a sin. The American Medical Association called the practice unethical, and then Surgeon General C. Everett Koop, argued that it was dangerous to society's health. However, Oregon still became the first state in the U.S. to legalize assisted suicide, and strengthening the state's reputation as mavericks by disregarding the advice of those who opposed physician assisted suicide.

Purpose of Study

Suicide or its attempt is not illegal in the US. However, assisting in a suicide is illegal except in Oregon. Recent proposals to legalize physician assisted suicide have started strong ethical, moral, legal and medical debates. Many involved in the debate are afraid that modern technology will force them to stay alive beyond the time of their natural death. Physician assisted suicide is one recourse available to individuals if legalized. The issue then changes and the question is not about whether patients should be kept alive against their will by medical technology, but whether a physician has the right to intentionally kill a patient when life is no longer desirable. Between 1994 and 2006, there were twenty one states that proposed legislative bills that would legalize assisted suicide, but all failed. Washington in 1991, California in 1992, Oregon in 1994, Michigan in 1998, and Maine in 2000 then voted on propositions to legalize physician assisted suicide. The initiative process brought the propositions to the ballot. This research will analyze the five states to determine what factors affected the outcome of these initiatives. These five states are important because they give a direct glimpse into the world of direct democracy by way of PAS initiatives.

The initiative is one method of direct democracy. Direct democracy challenges representative democracy. In a direct democracy, citizens vote on every issue. In a representative democracy, citizens vote to elect leaders who will represent them. The leader is then charged with voting on issues that are in the best interest of constituents. The initiative process provides an avenue for increasing the power of citizens. With an initiative, citizens are able to sign a petition if they are registered to vote. With enough signatures, citizens can set the political agenda as well as change legislation and public policy. Citizens may participate in direct or indirect initiatives. Citizens begin a direct initiative by circulating a petition to place a measure on the ballot whereas the legislature puts the measure on the ballot with an indirect initiative (Waters, 2002). Initiatives are started by the people and referendums begin in the legislature.

In an effort to change the law to allow assisted suicide, a group of volunteers gathered over the 150,000 signatures to make the measure eligible for ballot placement in Washington. In 1991, Initiative 119, which would have legalized active euthanasia, was introduced to the voters of Washington. The initiative was defeated 54-46%.

California was the first state to pass legislation permitting passive euthanasia. The California Natural Death Act of 1976 allowed the family of an unconscious patient or the patient themselves the right to request in a living will to be removed from life support machines (Jacobs, 1992d). In 1988, Americans Against Human Suffering started their campaign to legalize physician assisted suicide. Americans Against Human Suffering was unsuccessful in any of its efforts to change physician assisted suicide legislation. In the early 1990s, Californians Against Human Suffering were born from the group Americans Against Human Suffering. Californians Against Human Suffering proposed physician assisted suicide legislation that qualified for California's ballot. In 1992, California's Proposition 161, a measure virtually identical to Washington's Initiative 119, was placed on California's ballot. The proposal was defeated 54-46%, the same as Washington's proposal.

In 1989/1990, Oregon's chapter of the Hemlock Society introduced the "Death with Dignity Act," but the measure failed to move beyond the legislature. Senator Frank Roberts, a cancer patient, and husband of then Governor Barbara Roberts submitted a bill to legalize aid in dying in the Oregon Legislature. In 1991, during a legislative session, the "Death With Dignity Act" (SB1141) was introduced, but the measure failed again because it was not able to be brought for a vote (Humphry and Clement, 1998, pp. 225-226). In 1994, Measure 16, a proposal to legalize physician assisted suicide was placed on the Oregon ballot. Measure 16 passed 51-49%. The Michigan state legislature tried to pass a law that would criminalize physician assisted suicide in response to Dr. Jack Kevorkian's assisting patients with dying. In 1994, the Senate passed a bill which banned physician assisted suicide. In January 1994, Dr. Kevorkian tried to influence assisted suicide legislation by starting a petition. In 1998, Proposal B, a bill to legalize physician assisted suicide was introduced to Michigan voters. Michigan's Proposal B was defeated 71-29%. In 2000, "Maine's Death with Dignity Act," a proposal to legalize assisted suicide was placed on the ballot as "Question 1." It was very similar to the act in Oregon. Maine wanted to use Oregon as an example. Maine's citizens thought that if the measure passed in Oregon, it had a strong chance of passing in Maine. Supporters of physician assisted suicide from Oregon even came to support the citizens in Maine. Even with the support from Oregon, Maine's proposal was defeated 51% to 49%.

Research Question

This research analyzes those five states' efforts to legalize physician assisted suicide to determine what factors affected the outcome of these initiatives. The research asks and answers "why did PAS pass in Oregon and not in Washington, California, Michigan, or Maine?" This research will focus on the various factors that may shape or influence the outcomes of public policy and, more specifically, ballot initiatives. I use public policy models to explain this phenomenon. Six factors, including governor influence, interest group influence, culture, religion, age, and gender, are examined to explain the initiatives' outcome. This research is important because gaining a better understanding about why an initiative passes in one state but not in another can create information for policy makers about shaping and influencing policy decisions and outcomes in the future. More importantly, this research is significant because institutions help shape citizens' political attitudes. The initiative process is one method of empowering citizens and strengthening skills that will ultimately improve their civic abilities and increase political knowledge. According to Matsusaka (2002), outcomes are influenced by the decision making process. Research shows that initiatives impact state and local policy. For example, initiatives have also changed abortion and corporal punishment law (Gerber, 1996b, p. 99). Representative democracy has dictated how policy was made for centuries. Representative democracy was advocated by James Madison, one of the authors of the U.S. Constitution, as a way to solve the problem of factions. To Madison, a faction is "a number of citizens, whether amounting to a majority or minority of the whole, who are united and actuated by some common impulse of passion, or of interest, adverse to the rights of other citizens, or to the permanent and aggregate interests of the community" (*Federalist Papers*, No. 10). Madison called for a representative government and large electorates to ensure all interests of citizens were represented.

As we continue to move into the 21st century, we find that some elected officials are not as effective as they once were. Many political leaders elected to represent the interests of citizens have been caught in scandals and are not appropriately representing citizens but promoting self interests. Regularly it seems as if an elected official has behaved immorally or unethically. In December 1998, though acquitted in February 1999, President Bill Clinton was impeached for cheating with Monica Lewinsky and Paula Jones. In March 2008, New York governor Eliot Spitzer resigned after being involved in a prostitution scandal in which he used taxpayers' money to the fund services of a prostitute. Around the same time, in March 2008, Detroit Mayor Kwame Kilpatrick was indicted for lying under oath about an affair with his chief of staff and wrongly firing a police officer. Future generations may discover that direct democratic strategies are more effective than representative strategies. Whether through representative or direct democracy, it is the researcher's hope that by improving citizens' civic abilities and increasing their political knowledge, better policies will be made that will truly be representative of the masses and that government institutions will be greatly improved.

The Evolution of Assisted Suicide

The right to die, specifically euthanasia and physician assisted suicide, has become a prominent issue. Technology has advanced, providing people with the option to prolong life. However the same technological advances that save lives have also fueled debates on when and how to end life. Due to doctor-patient confidentiality, medical care decisions between patients and physicians are supposed to be kept private. However, decisions that are private between physicians, patients and their families have stemmed into controversial debates and become legal issues. Although there is no formal rule about who can participate in a patient's medical decisions, many are involved in the decision making process. Those involved often include the patient's appointed guardian, the patient's agent or proxy appointed by the patient's durable power of attorney for health care, the patient's spouse, the patient's children who are at least 18 years old, the patient's parents, the patient's siblings who are at least 18 years old, and the patient's close relatives or friends (Levin et al., 1999, p. 82).

Even though suicide has become a well known debate, the discussion of physician assisted suicide is not new. In ancient Greece and Rome, euthanasia and suicide was accepted by many. The government gave hemlock, a poison, to those who requested it and as a method of execution. The Greeks felt a death caused by disease or suffering was dishonorable. When a person died healthy, it was considered a good death (Leone, 1997, p. 13). As a way to rid themselves of shame, and pain from disease, many Greek philosophers advocated assisted suicide (Emmanuel, 1998, p. 176). As Christianity gained influence, attitudes about suicide changed. Christianity did not approve of suicide, and the practice was prohibited for many centuries (Emmanuel, 1998, pp. 176-177). In the 13th century, Henry de Bracton, one of the first legal treatise writers, observed that "just as a man may commit felony by slaying another so may he do so by slaying himself." Bracton on Laws and Customs of England 423 (f. 150) (G. Woodbine ed., S. Thorne transl., 1968).

The idea of euthanasia was rediscovered a few centuries later and became a prevalent topic in the writings of some Renaissance philosophers. Some of the philosophers' writings advocated euthanasia (Emmanuel, 1998, p. 178). Sir Thomas Moore stated that, "if a disease is not only incurable but also distressing and agonizing without cessation, then the priests and the public officials exhort the man, to free himself from this bitter life or else voluntarily permit others to free him" (Moore, 1515, p. 18).

Though some philosophers advocated euthanasia and suicide, there were others who opposed these practices. In 1644, Sir Edward Coke published his Third Institute. Coke believed suicide was murder. He agreed with Henry de Bracton's thoughts. He believed that if a person was sane and committed suicide, their "goods and chattels" should be forfeited (Washington v Glucksberg, 1997).

In the United States, on Dec 10, 1828, New York enacted the earliest law prohibiting assisted suicide (History of Assisted Suicide, 2008). Between 1857 and 1865, a New York commission led by Dudley Field drafted a criminal code that prohibited "aiding" a suicide and, specifically, "furnishing another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life" (History of Assisted Suicide, 2008).

Initial Legalization Attempts

Discussions about death and assisted suicide in the United States began around 1870. In Birmingham, Samuel Williams gave a speech about euthanasia. He advocated the use of chloroform "in all cases of hopeless and painful illness," not just to relieve pain, but to bring about "a quick and painless death" (Leone, 1997, p. 14). Williams' speech was significant because it emphasized lessening and eliminating pain (Krois, 2001, p. 9). The issue of assisted suicide gained more attention as medical technology changed in the 20th century. The change in technology prolonged life. The creation of morphine was of the utmost importance in this debate. Morphine was revolutionary and achieved attention because it reduced pain, and in some cases, hastened death by slowing the heart (Leone, 1997, p. 14).

Many in the medical profession disagreed with Williams, and as a result of the controversy his comments caused, more than half of the states in the US enacted laws that prohibited assisted suicide (Leone, 1997, p. 13).

In the 1900s, the Ohio legislature tried to make assisted suicide legal through "An Act Concerning Administration of Drugs to Mortally Injured and Diseased Persons" (Leone, 1997, p. 141). The legislation provided that, with three witnesses present, a physician was permitted to ask a dying patient if he or she wanted to die. At least three more physicians had to evaluate the patient to determine if he or she were terminally ill and if it was the patient's real desire to die with assistance (Worsnop, 1997, p. 778). The Ohio legislature did pass the legislation and discussions about assisted suicide stopped for a period of time (Leone, 1997, p. 142).

In 1937, Bill Number 135, which would allow for terminally ill patients to seek permission from a judge to end their life, was introduced to Nebraska's legislature (Krois, 2001, p. 10). After a patient sought permission, a commission chosen by the judge would review each terminally ill patient's request and medical history. If the commission recommended death, the judge would approve the patient's request to end his or her life (Kuepper, 1981, p. 106). Just as in Ohio, Nebraska's legislature rejected the bill.

The next year, the Euthanasia Society of America sponsored a bill that would legalize assisted suicide in New York (Krois, 2001, p. 11). The proposed legislation would allow terminally ill patients 21 and over to seek permission from the court to end their lives through euthanasia. Three people, a physician and two others appointed by the court would oversee all euthanasia requests. If the committee approved the request, the physician would euthanize the patient in the presence of the other two witnesses.

The legislation was supported by many legislators, but they chose not to approve the bill because they felt the public would not give their support (Kuepper, 1981, pp. 122-125).

Even though England and the U.S. were not able to legalize euthanasia and assisted suicide during the 1930s, Switzerland legalized euthanasia by a physician for people whose life was no longer beneficial or worth living (Emmanuel, 1994, pp. 793-802). During the late 1930s, eugenics was a part of some the proposals to legalize euthanasia. Eugenics seeks to change or alter human traits through intervention (Osborn, 1937, pp. 308-397). The idea is to eliminate or decrease human traits that are considered undesirable such as mental retardation, obesity, or low IQ's and increase preferred human traits such as higher IQ's and health.

In the late 1930s, the German Nazis also advocated euthanasia; however, their efforts were not as noble as others who sought to end the suffering of the terminally ill. They used the concept of eugenics and Alfred Hoche's and Karl Binding's book (1920), *The Permission to Destroy Life Unworthy of Life* as premises for the argument. If a person had certain ailments like mental illness or irreparable brain damage, Hoche and Binding thought that euthanasia should be permissible (Worsnop, 1997, p. 778). Hitler ordered widespread "mercy killing" of the sick and disabled. Adolf Hitler wrote a note to his private physician and chancellery officials that expanded their power as doctors. Hitler said in the letter that, "a mercy death may be granted to patients who according to human judgment are incurably ill" (Gardella, 1999, pp. 132-135). Under the code name "Aktion T 4," the Nazi euthanasia program sought to eliminate babies and very young children. Doctors and Midwives registered children from birth to three years old who showed signs of mental retardation, who were physically deformed or showed signs of other illnesses.

The Nazis sterilized those with hereditary diseases, and killed those they considered impaired and undesirable (Worsnop, 1995: Worsnop, 1997). Death occurred through lethal injection. Attention focused on these murders caused the prohibition of even the suggestion of legalized euthanasia and assisted suicide (Worsnop, 1995, p. 401; Worsnop, 1997, p. 778).

After WWII, during the late 1940s and early 1950s, the Euthanasia Society of America's membership increased, forming chapters in New York, Connecticut, New Hampshire, Pennsylvania, and Virginia (Krois, 2001, p. 13). The increase in chapters was important because as they were formed, the organizations continued to introduce bills that would legalize assisted suicide. For example, the voluntary bill that tried to legalize voluntary euthanasia for patients who suffered from an "irremediable condition" was introduced in the Idaho House of Representatives. The bill did not pass (Daar, 1995, p. 817).

Euthanasia became a major national issue in the 1960s and 1970s. According to Dowbiggin (2003), "as a national dialogue on dying spread, the idea of death with minimal pain and loss of dignity grew popular. Thanks to rising public interest in the concepts of patient autonomy and individual rights, euthanasia ceased being interpreted as a predominantly social or biological matter and was largely transformed into a personal issue. Privacy became the keyword of the new, revitalized euthanasia movement, and the term 'euthanasia' was steadily replaced by the phrase 'the right to die'" (p. 97). Much of this change and call for autonomy was unexpectedly perpetuated by Pope Pius XII.

In the late 1950s, he stated that passive euthanasia was permitted. Patients had a right to refuse life sustaining treatment without going against Christian doctrine (Dowbiggin, 2003, p. 98).

During the 1960s the civil rights movement occurred. During this time citizens fought for their own civil and personal rights. The right to choose was important to many citizens, and the right to choose manifested itself through abortion and physician assisted suicide debates. Many supporters of assisted suicide used the same arguments as abortion reformers to advocate the legalization of voluntary euthanasia. They felt that individuals should have the autonomy to choose what is best for them, especially if that autonomy would end needless suffering.

By the 1970s, interest in assisted suicide increased. Those who advocated the practice were interested in passive euthanasia or death with dignity (Krois, 2001, p. 14). Dying with dignity gives a terminally ill patient some control over dying because the patient is permitted to refuse any treatment that may prolong his or her life (Worsnop, 1997, p. 778). Euthanasia is a Greek term which meaning a “good death” (Glick, 1992, p. 12). In essence, euthanasia is the act of one person ending the life of one who seeks to die and has initiated the dying process. Euthanasia can be voluntary or involuntary. Terry Schiavo in Florida died on March 31, 2005 by passive euthanasia because her husband won the legal right to remove her feeding tube, which would have continued to provide nourishment, and prolonging her life. The killings by Dr. Jack Kevorkian, a pathologist from Michigan provides an example of active euthanasia. He helped numerous terminally and chronically ill patients end their lives because they chose to die.

The legal case of Karen Quinlan (429 US 922 1976) refueled the debate on euthanasia and the right to die with assistance. The case was a fight for the right to refuse treatments that would prolong Quinlan's life. Many states attempted to legalize death with dignity legislation, but failed to do so (Krois, 2001, p. 14).

The first state to legalize the right to refuse treatment was California, with the passage of the Natural Death Act (Scherer and Simon, 1999, p. 8). California's success was notable because it influenced how other states dealt with patient care. After California's success, all states in the United States passed varied legislation on patient's rights (Ulham, 1998, p. 115).

Many people were concerned about the increased use of life sustaining treatment, and as a result, support increased for a person's right to die (Krois, 2001, p. 14). As support increased for patient's rights, numerous groups were formed that advocated alternatives for patient care such as euthanasia, hospice, and palliative care. One group in particular, ERGO! (The Euthanasia Research and Guidance Organization) was formed to research assisted suicide practices and to educate people on these practices as well as establish parameters for effective euthanasia procedures (Otloswki, 1997, pp. 274-280).

In the 1990s, the issue of assisted suicide gained more interest than ever. Assisted suicide received much of its renewed attention because of the poor quality of palliative care and poor pain management for chronically and terminally ill. In addition, Dr. Jack Kevorkian, a Michigan pathologist, assisted in the suicide of Janet Adkins on June 4, 1990, who had been diagnosed with Alzheimer's. Adkins died as a result of the use of Kevorkian's "suicide machine."

The machine allowed patients to end their lives by administering a lethal dose of intravenous drugs. Kevorkian's license was suspended in the early 1990s, but he is allegedly responsible for killing more than one hundred people (Worsnop, 1995, p. 402).

In 1991, Washington also attempted to legalize physician assisted suicide through an initiative, but failed. Supporters of physician assisted suicide filed a lawsuit because the referendums failed. They thought that it was unconstitutional not to legalize assisted suicide. Terminally ill patients and their physicians blamed the state for not legalizing physician assisted suicide. The patients' lawsuit stated that their Constitutional guarantee of due process and equal protection rights had been taken away. The courts, in 1994, decided that the patients and physicians were correct. Criminalizing physician assisted suicide did violate their Constitutional rights. Washington State appealed, and, the United States Court of Appeals for the Ninth Circuit decided that the decision from the original case would stand. Prohibiting and criminalizing assisted suicide violated citizens' constitutional rights.

Following the Washington case, another case was filed in New York. The New York case stated that it was unconstitutional for New York to criminalize assisted suicide. The Federal Court of Appeals for the Second Circuit used the 14th Amendment's "equal protection" clause as the base for its findings. Terminally ill patients should not have their lives prolonged by life support but should reserve the right to seek assistance in dying from their physician. It was also decided that doctors should not be prosecuted for assisting patients with death by providing lethal drugs. These cases were significant because they showed that patients who were not on life support were not given the opportunity to seek assistance from their physician in dying.

In 1994, the right to die movement was finally successful. Oregon’s Death with Dignity Act, legalized physician assisted suicide through an initiative process. Fifty-one percent of voters in Oregon approved the legislation. The victory was not without problems. An injunction was placed Oregon’s Death with Dignity Act, but it was later reinstated after an unsuccessful campaign to resend it.

In 1997, Washington v. Glucksberg and Vacco v. Quill (the Washington and New York cases) were appealed to the United States Supreme Court. Both decisions were overturned, and it was decided by the U.S. Supreme Court that neither state law violated the 14th Amendment of the U.S. Constitution. The Court stated, “They neither infringe fundamental rights nor involve suspect classifications.” The Court also held that the Equal Protection Clause of the Fourteenth Amendment “creates no substantive rights” (Washington vs Glucksberg and Vacco vs Quill, 1997). Additionally, the court found that it is not unconstitutional for a state to make physician assisted suicide illegal. The ruling was significant because it gave power to the states. It gave every state the right to decide if physician assisted suicide would be legal or not in that state. Oregon legalized physician assisted suicide in 1997, making it the first state to legalize it.

In 2001, a statute was passed by the Dutch Parliament that legalized euthanasia and physician assisted suicide in the Netherlands. Though the media and many others around the world treated the statute as a major phenomena, euthanasia and physician assisted suicide had been legal since the 1970s due to several court decisions (Foley and Hendin, 2002, p. 97). The practices were so easily accepted in the Netherlands because of the country’s tradition of tolerance.

The Netherlands had become a refuge for Catholics, Jews, and free thinkers as the Dutch tried to gain religious freedom in the sixteenth and seventeenth centuries (Foley and Hendin, 2002, p. 97).

Many physicians and health care professionals are confronted with ethical issues of caring for terminally ill patients and patients who live with unbearable pain. As a result of these ethical issues, solutions are sought. Medical professionals, the courts, patients, and patients' families are involved in determining appropriate parameters in regards to life and death. Some believe that patients should have more autonomy in decisions regarding their care. However, giving more autonomy to the patient has not been without debate and conflict. The conflicts about appropriate values have encouraged communication about ethics and initiated new legislation and court cases. To gain a clear understanding of the controversy surrounding the physician assisted suicide movement, one must understand the factors surrounding the law. "One cannot understand the development of the law or of constitutional doctrine except if one sees it in larger context of social, economic, political, and cultural development " (Urofsky, 2000, p. 4). The social, political, economic, and cultural development contexts are essential.

Defining and Debating Physician Assisted Suicide

According to Kopelman and deVille (2001), "physician assisted suicide (PAS) occurs when a physician helps another person, by act or omission, to end his or her life voluntarily and intentionally" (p. 13). There are numerous ways in which people can die. For example, they can die by overdosing on medication prescribed by a physician. They could refuse life sustaining treatment or food.

Patients wish to end their lives for numerous reasons such as depression resulting from diagnosed illness and/or unbearable pain due to lack of resources necessary to receive treatment or medication. Multiple Sclerosis, AIDS, Alzheimer's, and Cancer are some conditions that lead people to choose assisted suicide rather than to continue suffering, deplete their financial resources, or burden family members.

Physician assisted suicide gives many a way to have autonomy over their medical care, and, more importantly, their lives. PAS gives the patients control because it is the patient who seeks assistance to end his or her life. The patient also has control because he or she ultimately ends his or her life after taking medicine prescribed by a physician. Physician assisted suicide ultimately questions, "Should a person who is diagnosed with a terminal illness, is mentally sound, and may have unmanageable pain, have the right to seek assistance ending his or her life?"

Those who support physician assisted suicide offer many arguments. One argument asserts that it is illegal for a physician to knowingly allow a patient to suffer. Thus, physicians have a responsibility to effectively manage or end the patient's suffering. Though palliative care is good, sometimes it can prolong a patient's suffering. Second, physicians must respect the wishes of their patients. Patients do have autonomy and are able to voice to the physicians their desires as they relate to medical treatment. If a person chooses death, his/her wishes should be respected. Third, even though abuses can occur, if PAS is legalized, safeguards can be implemented to minimize abuse. Fourth, a terminally ill patient's physician should be with him/her for the duration of his/her illness if the patients so choose, even if there are some challenges.

Patients should not feel that because they are terminal, they have been abandoned by their physicians (Bachman et al., 1996, p. 305). Five, sometimes the collective interests of the state and the interests of individuals conflict. The state normally tries to preserve life, but those who are terminally ill and wish to seek assistance ending their lives contradict the interests of the state. Advocates feel that patients' liberties should not be prohibited by the interests of the state. With this in mind, physician assisted suicide should be legalized for some.

Six, advocates also believe it is better to permit a small amount of assisted suicides performed under closely monitored guidelines instead of dangerous practices occurring in secret (Bachman et al, 1996, pp. 304-305).

Alternatively, people who do not support physician assisted suicide present several basic arguments. The first three arguments can be interpreted as religious in nature and would be upheld mainly by those who view religion as an important aspect in their lives. Religion helps guide how people live their day to day lives and the value they place on human life. One, human life should be honored and preserved. Two, closely related to this stance is, "where there's life, there's hope!" People who believe this argument believe that no one should ever give up on life. They believe that it is never too late to hope for a drug that will ease the situation or even for a spontaneous remission, or a "miracle" (Stillian and McDowell, 1996, pp. 282-283). Three, life deserves to be treated with reverence and sustained as long as possible.

The last two arguments are not religious in nature. Some critics believe that PAS can be a “slippery slope”. If terminally ill patients have a right to choose to end their lives, why shouldn’t someone who is chronically ill be able to when they no longer want to live? According to Behuniak and Svenson (2003), the “slippery slope is a continuum of ethical actions; the high point of a slanted line is defined by actions that are ethically acceptable” (p. 221). The further away from this point, the more ethically “suspect” an action becomes. And the more steps taken down the slope and away from the original position, the easier it becomes to slide to the other end of the spectrum and become the accepted norm.

Finally, there is a possibility that abuse may occur because those who may be poor or indigent will be encouraged to end their lives by physicians, family, or care takers. To prevent these abuses, those who oppose assisted suicide desire the practice to be illegal in all states.

The next section discusses the plan of study, which outlines the remainder of the four chapters for this research.

Plan of Study

Chapter 2 reviews the literature. It focuses on political theories that seek to explain the public policy process, and it also focuses on political, cultural, and demographical factors within a state that influence physician assisted suicide policy outcome.

Chapter 3 describes six hypotheses and the research design to provide answers to this study’s research questions. The research for this paper utilizes a case study approach. Case studies are qualitative in nature and are utilized to garner the details of how and why something may have happened. People always want to know what is happening in American politics, and why it is happening. By comparing political institutions and behaviors from state to state and community to community, people are able to identify and explain similarities or differences. Comparison is a vital part of explanation. I chose case studies to compare in depth factors in Washington, California, Oregon, Michigan and Maine that may have contributed to the success or failure of proposed ballot measures to legalize physician assisted suicide. Because case studies are so in depth, they provide insight into the interactions of groups as well as reflect idiosyncrasies of states. By comparing politics and public policy in different states and communities with different socioeconomic and political environments, we arrive at comprehensive explanations of political life.

This research on physician assisted suicide involves collecting data that analyzes a governor's position on PAS and his/her influence, interest group influence, political culture, religion, age, and gender to explain why physician assisted suicide passed in Oregon but not in Washington, California, Michigan or Maine. Analysis of Governor influence includes examining the State of The State Address for the governor of Washington, California, Oregon, Michigan, and Maine to see which issues he/she deemed important as well as examining any policies related to physician assisted suicide that these governors directly influenced. Analysis of interest group influence includes examining the number of interest groups involved in the fight for or against legalizing PAS in each state and how much money each group spent to influence legislation through ad campaigns. Strategies these interest groups used to mobilize to influence the PAS initiatives will also be examined. Analysis of political culture includes examining whether a state is classified as individualistic, moralistic, or traditionalistic as outlined by Daniel Elazar in his political culture indices. I also use Rodney Hero and Caroline Tolbert's categorization of state culture determined by the racial/ethnicity make up of a state to explore support for PAS. Analysis of religion includes examining available exit poll data for each state to determine the total voting population according to religion, and then determine how Catholics and Protestants voted to explore support for PAS. Analysis of age includes examining available exit poll data for each state to determine the total voting population according to age, and then determine how each age group voted to explore support for PAS. Analysis of gender includes examining available exit poll data for each state to determine the total voting population according to gender, and then determine how males and females voted to explore support for PAS. Exploring the affect of gender includes examining the percentage of males and females in each state as outlined by the U.S. Census Bureau.

Chapter 4 presents the case studies. It presents detailed accounts of the efforts to legalize physician assisted suicide in Washington, California, Oregon, Michigan, and Maine.

Chapter 5 presents the findings of this study, and applies the hypotheses described in Chapter 3 to Washington, California, Oregon, Michigan, and Maine. It also includes a discussion of the research findings, conclusions, and suggestions for future study.

CHAPTER 2: LITERATURE REVIEW

Public Policy and Causes of Policy Change in States

Many theories of the policy process can help us understand policy change and how it varies from state to state. "The adage that change is inevitable can be considered a truism when applied to public policy in the American states" (Ringquist and Garand, 1999, p. 268). Public policy could be defined as the combination of principles that guide how legal systems for each state operate. These legal systems include all the values which change with time, culture and other circumstances that bind communities and societies together (Goodwin-Gill, 1978). Laws are used to govern how one behaves in a society amidst norms, values, and rules. Cappalli (1997) believes that all legal systems include values such as change, expansion, equity, frankness, honesty, and impartiality (p. 393). There are numerous policies in the operation of any legal system, but probably the most important to many of these systems is the policy that teaches us to value human life. For example, the refusal of treatment and assisted suicide has become a major topic of debate and a source of dissension because many feel that human life should be preserved rather than destroyed.

The American states provide a great comprehensive data set for studying how state policy differs and why policy changes within these states. According to

Ringquist and Garand (1999), to understand the causes of policy change at the state level, one must go beyond consideration of only state-level characteristics. There are three general sets of forces that help to determine policy change in the states: internal state factors, external political factors, and specific policy factors (Ringquist and Garand, 1999). Internal state factors for policy making are the politico-economic characteristics of the state, the diversity and density of organized interests in the state, and the characteristics of the state political system. Demographic variables such as median income, religion, and population size also are considered internal state factors. Demographic variables have been invaluable in the growth of empirical analysis in the social sciences and particularly in political behavior. Demographics can be useful and may sometimes even be essential. Demographic variables are useful in three main ways. First, they are useful for simple descriptive or control purposes. Secondly, they can be used for explanation purposes. Thirdly, demographic variables are used to serve as reflection of proximal relationships through intervening factors. When the theoretically relevant quantities are unavailable, demographics that are relevant to the construct may be used to assist substantive understanding (Timpone, 1998, p. 55).

External political factors entail the intergovernmental environment that affects how decision makers operate within each state. Government regulation is example on an external factor. Regulation is a tool used by government to manage public services, and is important because it helps improve services and promote accountability. Within business and public services, the number of regulatory bodies is increasing, indicating a widespread recognition of the need for public accountability.

Specific policy factors entail characteristics that are specific to a particular policy. Policy-relevant knowledge, focusing events, and issue redefinition are important specific policy factors (Ringquist and Garand, 1999, pp. 274-275).

Until recently, the most influential framework for understanding the policy process, particularly among American scholars, had been the “stages heuristic,” or what Nakamura (1987) termed the “textbook approach.” It was developed by Jones (1970), Anderson (1975), and Brewer and deLeon (1983). This approach divides the policy process into a series of stages (usually agenda setting, policy formulation, legitimation, implementation, and evaluation) and discusses some of the factors affecting the process with each stage (Sabatier, 1999, p. 6). In the past decade or so, the stages heuristic model has received criticism and other theoretical frameworks have been developed to help explain political processes. A few of these new theories include the Stages Model, Policy Stream Model, Punctuated Equilibrium, and Advocacy Coalition Networks.

Stages Model

The stages model is a theory of the policy process. It is a model of policy-making depicted through policy cycles. The concept gained acceptance in the 1970s and 80s where stages were used to map the policy process. The model is significant for this research because it helps provide a simplistic view of how PAS policy has changed through the progression of specific stages.

The model outlines six basic steps. The first stage, problem recognition calls attention to the fact that something is wrong and that a solution is needed. The second stage is problem definition, during which is an attempt to define the problem.

If a problem is not properly defined, possible solutions may not adequately address the problem. The status quo is examined during this stage because the status quo helps to shape the context or meaning of the problem. The third stage helps set the agenda as public officials discuss problems and solutions to these problems. This stage might not occur if problem definition circles back to problem recognition. The fourth stage is policy formulation. The creation of policy by legislation and/or rules occurs. Policy formulation may be framed within rules or statutes. The fifth stage is implementation. Implementation entails putting policies into effect as outlined in the formulation stage. The final and sixth stage is evaluation. Evaluations are tools to measure the effectiveness of the policy. The basic question here is did the policy have its intended effectiveness or impact?

Each stage can circle back to a prior stage in a continual process. Many consider the stages model to be linear because of the progression of stages, but the model is best described as circular because of each stage's ability to circle go back to a prior stage. Charles Lindblom, Paul Sabatier and others say that it is an artificial approach, since the real world is not composed of neat, tidy steps. It is also called a textbook approach in that it does not account for uncertainties of real world experiences with multiple levels of complexities that fall outside of this confined view of analysis. It overstates the rational nature of the policy making process. Sabatier and Jenkins-Smith (1993) criticize the stages model because it cannot be tested empirically. But also because it does not provide causal explanation of movement between steps it characterizes policy as top-down without considering street level actors, and it ignores multiple levels of government and complex interacting cycles.

Additionally they criticize the model because it allows for analysis through the cycle, only in the evaluation stage (p. 3). The big advantage to the model is that it allows the policy making process to be considered within a more manageable framework. Through stages, the complex real-world can be broken down into cycles, or parts, for analysis. The tool by itself is perhaps inadequate because it does not take into account politics and the simplistic way that it approaches the world.

Policy Streams

Because of the noted limitations of the stages model, three more political theories that are more realistic are introduced that seek to explain the political process and how policy decisions are made. The first of these three political models describes the policy streams. John Kingdon's book contributed directly to the study of agenda-setting with his book, *Agendas, Alternatives, and Public Policies 2nd ed.* (1995). His study focused on how issues come to be problems; how they come to the attention of public officials; how agendas are set; and why ideas emerge in their specific time. This theory is significant to the research because it helps provide a better understanding of PAS as a political issue, how political officials became involved in the issue and how specific solutions have been created to properly address PAS.

Kingdon coined the term "window of opportunity". The "window of opportunity" has become a popular metaphor that aids in the understanding of one important aspect of the public policy-making process. It could be considered an external factor that influences policy change. A policy window opens when the problem, political, and policy streams meet. The problem stream involves identifying a problem.

Identifying the problem usually comes from some type of indicator or focusing event. Hurricane Katrina in 2005 was a focusing event. It alerted the public and the government to the economic disparities that plague many citizens, but it also signaled the aging structural problems of the New Orleans' levies. The events following the hurricane spoke to the harsh treatment that some economically impoverished citizens face. As a result, there was a harsh outcry for change.

The policy stream is comprised of possible solutions to policy problems. The political stream is a mix of how the public feels about the problems and possible solutions. Often, policy makers find that there are numerous solutions to problems, but the public does not agree with the proposed solutions and sometimes there are just not enough resources to implement proposed changes. The political stream essentially analyzes specific aspects of the problem and whether or not it can be solved. The streams are independent and driven by a variety of forces. Political actors are a major part of the three streams because it is the policy actors who seek to influence the agenda and provide solutions to problems in the form of policy. Thus, a window of opportunity occurs when the political stream changes or feasible solutions and policies are able to address a new problem (Kingdon, 1995, p. 203).

John Kingdon (1995) notes that the "window of opportunity" for changing policy comes and goes very quickly. Normally problems are not placed on the agenda if the problem and political streams do not converge. Once a problem is identified, policy actors must act quickly by devising feasible solutions and then seek to move the problem or issue to the agenda for consideration. An agenda is the combination of problems or issues that have been brought to the attention of citizens and public officials, and may include actual problems and alternatives to the problems. It is imperative that, when a problem or issue arises and political conditions are favorable, the policy stream produce feasible alternatives to solve this problem. Success normally comes to those who can define the problem as well as provide solutions to the problem.

Punctuated Equilibrium

Punctuated equilibrium is another policy theory that seeks to explain political processes. This theory assumes that small changes and a measure of stability usually guide political processes, but sometimes large and dramatic changes are made given a particular situation (Baumgartner, Jones, True, 1999, p. 97). As outlined in chapter one, the right to die movement and physician assisted suicide is not new, but has been around for decades though its level of importance as a political issue has changed depending upon political situations and historical events. This theory is significant to the research because it helps to explain the progressive change of PAS policy through the years.

During periods of stability much agreement exists on how problems are defined and where they are on the decision making agenda (Baumgartner, Jones and True, 1999, p. 99). At times, issues emerge that bring about change in policy and/or in institutional arrangements. These new institutions create a basis for new periods of stability. When there is instability, there is access to the agenda and the dominant policy subsystem is open to criticism or enthusiasm.

Agenda access punctuates the equilibrium and creates durable institutions that will remain intact after the initial wave of criticism and enthusiasm. When issues come to the peak of attention, they can have an ongoing effect. They show that media is a crucial element in times of instability by directing attention to different aspects of the same issues over time and shifting attention from one issue to another. Shifting attention from one issue to another serves to reinforce and reflect what happens within policy making institutions and allows processing of wider variety of issues over time. Baumgartner and Jones believe that through the interaction of policy subsystems and reinforcement by media, agenda change occurs. Dr. Jack Kevorkian's legal battles pertaining to assisted suicide and involuntary euthanasia serve as examples of how the media shapes the direction of a debate. Because of the consistent media coverage, these issues were placed on many states' agendas. Assisted suicide legislation has changed over time and will continue to change during these periods of instability as the media continues to draw attention to the assisted suicide debate.

Punctuated equilibrium arises as these policy actors continue to identify and seek to solve a progression of issues. "Change occurs, but in 'bursts and lurches' to other issues making better use of limited attention spans and limited information processing" (Baumgartner, Jones, True, 1999, p. 103). According to Charles Lindblom (1959), a major theorist who developed incremental decision-making, change in policy evolves slowly as opposed to rapidly and dramatically. This view sees policy making or change as a series of small steps or as Lindblom calls it, "Muddling Through". Muddling through occurs because of limitations in time, resources, information, and humans' limited ability to process information. Punctuated equilibrium assumes that class bias is necessary in order for the political system to function. It is very important to recognize who holds the power in the political system.

According to C. Wright Mills' (1956), *The Power Elite,* there is a small group of the population who holds the majority of the power. The "elite group" is made up of top military officials, government officials, and corporate or business officials. Because of its position of power and vast resources, the elite have the ability to influence policy outcomes and decisions.

Advocacy Coalition Network

Advocacy Coalition Network is the final theory that seeks to explain political processes. Advocacy coalition network considers part of external factors that influence changes in policy. As previously stated, the stages model is limited and Paul Sabatier and Hank Jenkins-Smith (1999) created this theory as an alternative to the "stages model" or policy cycle framework. The basic goal of an advocacy coalition network is to detail how competing advocacy coalition influence policy changes. This theory is significant for this research because it gives a better understanding of how competing interest groups influenced the outcomes of the PAS initiatives in Washington, California, Oregon, Michigan, and Maine.

Sabatier shows that ideas, alternatives, and analysis are necessary inclusions in the political stream if change is to happen. In an attempt to build a better theory, he proposes comprehensive processes to predict policy change. As opposed to an iron triangle or policy cycle approach (stages), Sabatier shows a policy process in which boundaries and various occurrences shape the interactions and behaviors of subsystem actors (Sabatier and Jenkins-Smith, 1999, pp. 120-121). All those who participate in introducing and analyzing policy ideas make up the subsystem, but those who actually make policy decisions are not a part of the subsystem. These actors would include patients, family members, medical professionals, and organizations involved with physician assisted suicide as a policy problem. It also extends to those implementing policy rather than just making policy.

Policy flows through a number of advocacy coalitions to produce output, learning, and eventually feedback. Fischer (2003) describes advocacy coalitions as a collection of political groups who have similar interests and join forces to debate against other policy coalitions who are also concerned about the same policy issues. "Coalitions" can consist of alliances involving persons who hold government positions, professors and administrators at universities or colleges, interest groups, or corporate and business officials. Of the previous groups mentioned, the media and interest/advocacy groups are particularly significant.

For example, interest groups and the media have been an integral part of the PAS movement. There are interest groups that support the legalization of assisted suicide and at least an equal number that oppose it. The media has captured the arguments of the groups who advocate and oppose legalizing assisted suicide and has presented these arguments in television ads, news exposes, journals, and magazine articles. The media helps to frame or shape how the public views a policy issue through its presentation.

Feedback through the system is considered to be "policy orientated learning". Policy coalitions learn from change and through this change they use strategies to develop new models. The policy subsystem interacts with other policy subsystems and the wider social, political, and legal world. Parameters are defined through stability and change.

Sabatier and Jenkins-Smith tested the model through the behavior of actors within the subsystem and policy orientated learning process (Sabatier and Jenkins-Smith, 1999, p. 135). However, the model is better equipped to predict policy change where government is more open to discuss and seek consensus among coalitions.

Richard Hoefer's (2005) study developed a model of the effectiveness of human services interest groups and tested the model in four states to understand how these groups can advocate their positions and become more effective in the political arena. Hoefer used variables such as resources, strategy, relationships, use of coalitions, and group policy position that have helped explain interest group effectiveness at the national level to explain the effectiveness of interest groups on the state level. Results showed that what works on the national level does not always work on the state level. The model best fit the data in Mississippi, followed by Minnesota, Texas, and Pennsylvania (Hoefer, 2005, p. 224). Resources, strategy, relationships, use of coalitions, and group policy position did not prove to be the best indicators of a group's effectiveness. The relationships and the policy position variables were not major indicators of interest group effectiveness in any of the four states. Only the resources variable was significant in more than one state, and only in Mississippi was more than one variable significant. Hoefer concluded that because each state is different, advocacy practice knowledge must be gathered by each state, and that the decentralization of policy making must lead to the decentralization of knowledge gathering.

As devolution from the national to state government occurs, states will be faced with many important policy decisions. Ezell (2001) stated that, "Policy change is now closer to home than it used to be. More and more policy and funding decisions are being devolved to the states. The governmental processes to make and change policy are more accessible to clients and advocates than ever before" (p. 196). This truth is evident as citizens and interest groups in various states seek to legalize assisted suicide using direct democracy.

Public Opinion

As seen in the aforementioned theories, public opinion and core values have a political influence. Public opinion is important because it is one of the main catalysts for influencing public policy. It is comprised of the beliefs citizens hold regarding to issues and problems that affect them (Gray and Hanson, 2004, p. 25). In the book, *Statehouse Democracy: Public Opinion and Policy in American States,* Erikson, Wright, and McIver (1993) argue that the key to understanding state politics and policy is to understand the process and importance of public opinion within each state. However, relations between public opinion and public policy are at best complex. This section will explore why public opinion is important in democracy, and more specifically direct democracy. Erikson, Wright, and McIver (1993) presents a model for comparing public opinion across states by using CBS News/New York Times national polls. The media gives voice to public opinion and is one of the main ways public opinion is expressed. Public opinion was measured by asking the question, "How would you describe your views on most political matters? Generally, do you think of yourself as liberal, moderate, or conservative?" Public opinion (X) correlates very strongly with policy outcomes (Y); therefore the authors conclude that state politics are responsive. The effect of X "overwhelms" the explanatory power of the controls (Gray and Hanson, 2004, p. 25).

How a person feels about an issue is reflected in public opinion poll results and, when public opinion is expressed, policy is often made that reflects these opinions. Public opinion usually has an influence on state and national policy and significantly impacts highly salient issues and social policy (Burstein, 2003, pp. 29-31). However, all laws do not reflect the public opinion. Such is the case with physician assisted suicide. This is a highly controversial and leaves many debating the best policies for such a complex issue. Polls show that many Americans support physician assisted suicide. In a poll conducted for the Washington Post on March 22-26, 1996, results showed half of the respondents supported legalizing physician assisted suicide. Support for assisted suicide usually varies according to demographics. In this poll, 57% of voters age 35-44 supported assisted suicide while 54% as voters 65 and over opposed its legalization. 70% of African Americans Blacks also opposed the practice. Over half of the voters with incomes less than $15,000 opposed as well. Even with support for legalizing physician assisted suicide, Oregon is the only state in the US that has adopted legislation in favor of the practice. In Oregon, about two-thirds of the citizens supported the practice before the November 1994 vote. Support dropped for the measure, but physician assisted suicide was still legalized by a vote of 51.3% to 48.7%.

Most often when policies do not reflect citizens' preferences, citizens use alternatives to change policy such as direct democracy. Direct democracy provides hands on participation for citizens through signing petitions, voting, and recalling elected officials. The next section discusses how citizens can use direct democracy to change policy.

Direct Democracy in the States

If public opinion is a catalyst for influencing policy, direct democracy is its tool. Direct democracy contrasts representative democracy by gives autonomy and power directly to the people. Specifically, power goes to those who are registered to vote and who participate in the different forms of direct democracy. Citizens are able to vote for themselves instead of electing public officials to vote for them.

The Declaration of Independence proclaims that governments gain their power because the people allow it. Basically, pure democracy is based on the people's ability to express the general or collective will of the people. The founders created a republic in the US in which power was given to the people. Leaders could only gain power if the people approved. It was always the wish of the forefathers for the leaders to govern in such a manner that the will of the people was reflected. Realistically, they were concerned that the leaders would not govern with the interest of the people in mind but according to their own interests. James Madison believed that man is self-interested and that a representative government was needed as a solution to self interested leaders.

He stated that a representative government would “refine and enlarge the public views by passing them through the medium of a chosen body of citizens” (*Federalist papers*, No. 10).

In his book, *The American Commonwealth* (1900), Bryce gave one of the initial American definitions of public opinion. He defined public opinion as “the aggregation of all that is thought and said on a subject” (Bryce, 1900, p. 251). Many felt that the opinion of the public did not reflect the actions of state governments. Those who wished to make the founders’ vision a reality advocated direct legislation by the sovereign people (Special Committee of the National Economic League, 1912).

For a brief period in America, direct democracy prevailed. In 1913, U.S. senators began to be directly elected by voters. In 1920, women were permitted to vote, and between 1904 and 1918, over nineteen states adopted initiative or referendum capability (Bowler and Donovan, 1998, pp. 4-5). Some states adopted both forms of direct democracy. After this period, the growth and spread of direct democracy slowed, but the past decade renewed interest in understanding direct democracy. Studies have focused upon issues such as the degree of knowledge voters have, how closely ballot outcomes conform to public opinion, how political parties behave in ballot campaigns, and how ballot outcomes are ultimately determined (see Bowler and Donovan 1998, 2002; Bowler, Donovan, and Tolbert 1998; Ellis 2002; Gerber 1999, 2004; Smith and Tolbert 2001; Tolbert, Grummel, and Smith 2001). Much of this research recognizes the central role that groups play in these campaigns (Boehmke, 2002).

Modern direct democracy involves giving power to the people through the Initiative, the Referendum, and the Recall. The Referendum helps determine if a particular law passed by the legislature should remain in effect. The people are given the power to reject legislation that is not in their best interest. This action allows citizens an opportunity to veto government legislation. With the Recall, the people are given power to vote to oust an elected official.

Direct democracy has been discussed as a method citizens use to change policy. As previously stated, there are several forms of direct democracy that citizens can use. Citizens tried to legalize PAS through initiatives so it is important to provide the history of initiatives and referendums as well as arguments for and against direct democracy so readers can have a better understanding of the initiative process and why citizens would choose the method to change policy.

Initiatives/Referendums

Encouraged by the abuse workers and farmers received in the late 1800s and early 1900s, the Progressives created national citizen networks to help poorer farmers banding together to rid themselves of the crop-lien system. These workers and farmers were known as Populists (Goodwyn, 1978, p. 320). Initially, the Populists' wanted a democratic system and equality for all. They never wanted business leaders or the corporate people to have total control, but they wanted to work together to achieve their goals cooperatively. However, the Populists' found that what they wanted was not their reality, and if the people were to have any power and influence, they needed to devise and implement a plan that gave them control over governing systems.

They believed that both the Democratic and Republican parties of their era were controlled by trusts and monopolies. From 1898 to 1918, support was provided to countless citizens by the Progressives. The progressive reform movement was supported by many upper-middle-class, white, Anglo-Saxon, Protestant Groups, who felt that political “machines” were catering to the votes of recent immigrants such as the Irish, Italians, eastern and southern Europeans, working class people, Catholics and Jews (Dye and MacManus, 2003, p. 40). To reduce the influence of politics, parties, and politicians, the Populists and Progressives advocated a wide range of devices designed to bypass political institutions and encourage direct participation by voters in public affairs. Progressives wanted to hold legislatures accountable to responding to the people and give voters a direct say through the initiatives and referendums. Their perspective on politics was based on two beliefs. First, they felt that political organizations were corrupt and that many of the ills of American democracy were directly attributable to political parties, party bosses, state legislatures, mayors and city governments. Second, they felt that individual citizens wanted to exercise greater control over government and were more capable to determine for themselves the public good (Magleby, 1984, p. 25).

The Populists and Progressives were responsible for some of the 20th century’s constitutional improvements for citizens through several methods of direct democracy. The initiative utilizes a petition where a specified number of voters can introduce an amendment to the constitution or state statute to be placed on a ballot for consideration. The initiative is ideologically neutral; both liberal and conservative groups can use this device to circumvent the system and bypass legislatures while still giving power to the citizens to introduce legislation and amendments (Dye and MacManus, 2003, p. 44).

Citizens may propose initiatives to limit the terms of public officials, place tax limitations, and increase minimum wages (Dye and MacManus, 2003, pp. 47-51). Though varied by state, the basic steps to pass an initiative are as follows: First, a proposal is created by those whose advocate a change in legislation. Second, the proposal is sent for state review, after which time supporters began to seek signatures on a petition which outlines the proposed legislation. Finally, the signatures have been collected and verified by the state, the measure is then placed on the ballot for consideration (Gray and Hanson, 2004, p. 134). Referendums seek the approval of the voters before decisions made by the legislature can be made law. Referenda on state laws may be submitted by the legislature or demanded by popular petition. Referenda can be proposed for such diverse purposes as prohibiting same-sex marriages, granting school vouchers to parents for any school they choose, ending affirmative action and racial preferences and prohibiting abortion (Dye and MacManus, 2003, pp. 47-51). There are three basic forms of referendum in the United States: legislative, advisory, and popular referenda. All states have some form of referenda in which voters must give their approval on proposed legislation. Advisory referendums are legislatures' way of monitoring public opinion. Measures are placed on the ballot even though no vote is necessary for the measure; the vote is just to determine if voters will or will not support the measure (Dye and MacManus, 2003, p. 40). Popular referendum allows for the change of legislation that may have already been enacted by the legislature, but not approved by the voters. Through petition, citizens seek to have the legislation approved or removed. Recall elections help voters remove elected officials before their terms are over. Normally a recall election is initiated by a petition.

An elected official is rarely removed from office in this way because a recall requires an expensive petition drive as well as a campaign against the incumbent.

Beginning in 1898 with South Dakota, state after state acquired the initiative and referendum. Initiatives and referendums traveled quickly throughout the states because many citizens felt that laws were being passed that did not reflect the best interest of the people. The people were burdened with a poor economic system, inequalities, and unethical business dealings. By 1911, ten states had adopted the initiative and the referendum (Weissberg, 1976, p. 64). Initiatives were used heavily in states like California, Utah, Oregon, and Maine. These states had over140 statewide initiatives in the twentieth century (Bowler and Donovan, 1998, p. 5). The idea even gained enough respectability to be endorsed by the two leading presidential candidates in 1912, Woodrow Wilson and Theodore Roosevelt. Woodrow Wilson expressed his support for direct democracy as a mechanism to “take power from the bosses and place it in the hands of the people” (Jost, 1990, p. 473).

The initiative was used often in the early 1900s, but by the 1940s, fewer voters used the process. Oregon, the first and only state to legalize physician assisted suicide, in 1994, was also the first state to ever pass an initiative in 1904. Oregon has been one of the leading states to use the initiative process along Colorado and California. Between the 1910 and 1940, state ballots contained more than two hundred initiatives (Bowler and Donovan, 1998, p. 5). In the 1970s and 1980s, however, there was substantially greater use of the initiative, its use peaking in the 1990s (Clark, 1997, p. 75). Between 1971 and 2000, over eight hundred and fifty initiatives were placed on state ballots. These initiatives had a forty-five percent success rate.

As times and situations change, citizens also want a change in legislation. Each year more and more initiatives are placed on ballots by citizens who seek these legislative changes. As the numbers of initiatives have increased, so have their success rates. The 1990s saw a proliferation of initiatives, with possibly more successful initiatives in the 1990s than any other time period (Waters, 2004). At least twenty-three state constitutions have approved and enacted some form of initiatives led by citizens (Bowler and Donovan, 1998, p. 5). Oregon, California, Colorado, North Dakota, and Arizona have adopted some form of the initiative process and use the process more than many other states. These states are responsible for at least fifty percent of initiatives. However, the success rate in these states is only about forty percent (Bowler and Donovan, 1998, p. 5). Petition requirements may explain why these states use initiatives so often. For example, the state of Colorado requires fewer voter signatures than Oregon, California, North Dakota, and Arizona. Of the five, Colorado has the lowest threshold in the number of signatures required, with 5% of those who voted in the last Secretary of State election. Arizona requires fifteen percent of voters' signatures when trying to pass an amendment to the constitution and ten percent when trying to pass a statute (Waters, 2002). California continues to have an increased usage of direct democratic efforts. 1990 set a record with over twenty seven measures on a ballot. In 2004, ten initiatives and a referendum on a ballot needed to be considered by citizens. There are not many limits placed on the types of issues that can be placed on the ballot. Some issues that have reached the ballot include abortion, drug use, right for gays and lesbians, and prohibitions on the hunting of wolves and mountain lions (Bowler and Donovan, 2008, p. 131). A few successful initiatives have allowed for a change in tax reform, women's ability to vote, the number of hours one can work, the minimum wage, physician assisted suicide, and even how the environment is treated. As the partial list illustrates, initiatives have made, initiatives are far reaching. They are significant because successful initiatives speak to all situations which affect citizens' lives. Change would not easily occur, if at all, in many of these situations if citizens had no method of directly influencing legislation. A well known and influential initiative was California's, Proposition 13. In 1978, Proposition 13 was approved by an overwhelming majority California's citizens. The approval of this proposal amended the state's constitution. Citizens started the petition after they felt they were not getting any help or tax relief from legislators. Every year California's property taxes increased due to housing inflation. They reached more than forty-four percent in 1978 (O'Sullivan, Sexton, Steven, and Sheffrin, 2007, p. 3). In the tax act, real estate taxes were to be capped to no more than one percent of the property's cash value. Had citizens not approved Proposition 13, taxes would have probably continued to increase, and the state would have had a surplus of funds near ten billion dollars (O'Sullivan, Sexton, Steven, and Sheffrin, 2007, p. 3). Proposition 13 prompted several states to include property tax reduction measures on ballots. The success of the measure also encouraged California voters to use ballot measures to change other aspects of citizens' lives. Citizens sought change in elected official's term limits, school funding, and marijuana for medicinal purposes. Proposition 13 garnered much attention throughout the US and changed the actions of taxpayers in other states.

Between 1979 and 1984, more than fifty-eight measures appeared on ballots throughout the states seeking tax relief (O'Sullivan, Sexton, Steven, and Sheffrin, 2007, p. 1). States with constitutional provisions for citizen initiatives were more likely to join the "tax revolt", than states without citizen initiatives (Dye and MacManus, 2003, p. 44).

Arguments For Direct Democracy

Even with the growth of direct democracy, there are many who oppose it. Supporters of direct democracy have made many arguments for using initiatives and referendums. Many of these arguments for direct democracy are born as a result of criticisms against representative democracy. First, elected officials often are very different from those who elect them. They usually differ in class, education, opportunities, political experience, gender, and race. Because of these differences, many citizens feel that elected officials cannot truly represent them. Direct democracy gives citizens a method by which they do not have to rely on elected officials. They can bring their concerns and interests directly to the public through direct democratic efforts. Also, supporters feel that direct democracy enhances government responsiveness and accountability (Cronin, 1999, p. 10). If government officials are never challenged by citizens for insubordination and unresponsiveness, positive change for citizens may never occur. Third, voter interest is stimulated by direct democracy and election-day turnout is improved. When citizens feel like their interests are being represented, they tend to participate more. Fourth, supporters also believe that direct democracy increases trust in government and diminishes alienation (Dye and MacManus, 2003, p. 42).

Thomas Cronin (1988), through survey and poll research was able to garner insight on how Americans feel about direct democracy. Despite the many arguments against direct democracy, he found that Americans generally support the idea of direct democracy. He believes that most Americans do not view direct democracy as a radical process that subverts the basic character of American government but as a measure that complements representative democracy and assures that representative bodies remain accountable and representative (Cronin, 1999, p. 10). Most Americans seek direct democratic efforts when they feel that elected officials have violated the public trust.

By analyzing several types of empirical data, Smith and Tolbert (2004) found that the initiative process has been beneficial and has helped shape democracy in America. They believe that citizens have been positively affected by the process indirectly and as a result voter turnout has been promoted, confidence in government has grown, and civic engagement as well as political knowledge has increased (Smith and Tolbert, 2004, p. 145).

Arguments Against Direct Democracy

Direct democracy sounds good in theory, but those who oppose it maintain direct democracy is not good in practice. Critics of direct democracy argue that it encourages majorities to sacrifice the rights of individuals and minorities. Another objection to direct democracy is that voters are not always politically skilled or informed enough to cast votes on many issues. Some Americans do not exercise their voting rights but like to choose representatives who will vote for them because they believe the officials are better equipped to make policy (Cronin, 1999, p. 10).

Also, critics believe that direct democracy gives preference to special interest groups by allowing them to use money and influence to wage campaigns on issues that concern them. Further, direct democracy is criticized because the checks and balances system in the U.S. form of government is bypassed. Not only is direct democracy criticized, but there are also specific criticisms of the initiative process. Critics claim that the initiative process is too expensive and that the money could be used for better purposes. Initiatives are often accused of being complex and hard to comprehend. Some voters do not possess the necessary skills to fully understand information on a ballot and may become confused. Confusion is particularly evident in situations when counter initiatives or combined measures are on a ballot. However, Bowler and Donovan (1994) found that proposition campaigns can often be a learning process for the undecided. Another argument from critics is that the media can pollute the initiative process. Media campaigns often provide wrong or misleading information on an issue. In many instances, the media slants or frames an issue according to how they see it or how they want the public to perceive the issue. Framing helps the public make sense of occurrences and decide what the issues really are. Many have studied how the media influences opinion change on ballot propositions with a large impact on opinion change. Additionally, Bowler and Donovan (1994) found that voters rely on different sources of information, not just the media. The more sources they use to get information on an issue, the more informed they are.

The more informed they are, the better their decision-making skills when voting on propositions (Bowler and Donovan, 1994, p. 432). A final criticism is that the courts have become involved in initiatives. Those who do not support a particular issue use the court to fight the battle for them. Often the courts are able to defeat the initiative.

Why Use Initiatives?

In the face of the aforementioned policy theories – the window of opportunity, stages model, punctuated equilibrium, and advocacy coalition networks that help explain the influences and processes of policy change, one can also question, why citizens would choose to use the initiative process as opposed to using another process to change policy? Simply put, initiatives give power directly to the people! Using initiatives gives citizens the power to directly influence legislation, make laws, recall or repeal laws, and amend the constitution through initiatives and referendums.

Further, research shows that diverse, salient, and/or controversial issues may not be addressed by elected officials and often needs to be addressed through ballot measures (Bowler and Donovan, 1998, p. 5). Matsusaka (1992) found that issues pertaining to taxes like Proposition 13 and various social issues such as gun control, teenage pregnancy, or immigration tend to be addressed by initiatives. Third, when there is a division in government because of political parties or ideological debates, initiatives are also more likely to appear (Matsusaka, 1992). Fourth, Matsusaka and McCarty (2001) found that initiatives are used more often in diverse or heterogeneous states than in homogeneous states. Matsusaka (1992) also believes that ballot measures are a prediction of how serious a voter is about a particular issue. Voters may want to change some issues yet not feel strongly enough about them to initiate change. In other cases, citizens feel strongly enough about an issue and choose to seek change directly through initiatives. When support is extremely strong for an issue, legislators' attention may also be gained and change ensues. Even though elected officials may oppose policies such as tax cuts or term limitations, the initiative allows voters to adopt these types of policies and as a result citizens are expected to view government as more responsive to citizen preferences (Smith and Tolbert, 2004, p. 74). Initiatives correct for the imperfections in legislative elections. Ultimately, initiatives make policies that reflect public opinion. In states where there are no initiatives, legislators have less information about issues concerning citizens and may find it difficult to determine what they want. Studies have shown that some public policies in initiative states such as abortion, death penalty, and civil rights coincide more with public opinion than in states without the initiative (Gerber 1996; Matsusaka 1995).

Gerber (1996a) discussed how different the initiative and legislative processes are. She believed that "Different outcomes often result when laws are made by initiative and by legislative politics, even on similar issues and policies" (Gerber, 1996a, p. 283). Gerber found that initiative can have a positive affect on policy without being used. Issues have a better opportunity to pass by legislatures in favor of the voters when they carry a wide base of support from citizens because legislators want to keep away the threat of an initiative or referendum (Gerber, 1996b, p. 124).

In those instances where initiatives are used, as time progresses, initiative campaigns tend to become more elaborate and expensive. Television, radio, and newspaper advertising are most often a part of the process to collect signatures on petitions as well as part of the process to gain the attention of the voters. When ads are aired, citizens become more aware of the initiative and citizens may pay more attention to media sources about the initiative. Advertising and utilizing media services, regardless of the form, are expensive. Interest groups have sponsored many of these initiative campaigns. Opposition campaigns to initiatives are sometimes funded by interest groups as well. There are many who are skeptical of citizens' initiatives and use their money and influence to defeat them. Those who are skeptical may include lobbying groups and political office holders. As a tactic to oppose initiatives, some opposition groups use "counter initiatives." These "counter initiatives" purposely add an initiative to the ballot that discredits support for the popular initiative (Dye and MacManus, 2003, p. 48).

V.O. Key believed interest groups and the elite are important to the initiative process because of their influence on shaping public opinion. Key stated, "Mass opinion is not self-generating; in the main, it is a response to cues, the proposals, and the visions propagated by the political activists" (1966, p. 557). However, before a person can be influenced by the opinion of elites, he/she must have knowledge or be aware of the issues at hand. For many citizens, awareness of issues can come from the media through television, radio, newspaper, but also through ballot initiatives.

According to Smith and Tolbert (2004), "ballot initiatives may have the most impact in low-information elections, such as midterm elections and noncompetitive presidential elections, providing voters with additional political information" (p. 70).

Even though elites have influence over public opinion, the amount of influence varies according to the degree a citizen is aware of the issues, the level of involvement from the elites, and according to the tone of the elite's message (Karp, 1998, p. 152). Elites tend to have greater influence when there is more consensus among other elites about an issue (Karp, 1998, p. 151).

The initiative can be an easy process; however, this is often not true. Interest groups have power, wealth, and influence. Passing legislation is difficult because of the numerous phases of the process and the large amount of approval needed, but stopping a law from passing is much easier because only a few key law makers have to oppose. Interest groups understand this process. As a result, they partner with these law makers in order to provide opposition for the initiative. Special interest groups may oppose the process because citizen interest groups usually are encouraged more by the process than special interest groups who are driven by money. Smith and Tolbert (2004) found that citizen lawmaking alters the strategies and composition of interest groups and also citizens' attitudes and behavior towards interest groups (p. 111). As seen, the initiative is another place where conflict occurs politically. According to Richard Ellis, "The initiative process does not offer a respite from interest group politics but rather a new venue in which most the same old interest groups contest for power" (Ellis, 2002, p. 109). Interest groups have power because much of the initiative's impact depends on the demands of interest groups (Bowler and Donovan, 2008, p. 132).

Boehmke (2002) has studied how interest groups are impacted by direct democracy. He found that initiatives positively impact interest groups, and groups increase in size as a result of the initiative process.

Boehmke (2005) also studied the factors that determine the number of initiatives that appear on state ballots. He found that states that have more citizens also have more initiatives in certain areas. However, states that have more economic divisions have fewer initiatives.

Ultimately, direct democracy provides an access point to the legislative process and allows people outside of the legislature and traditional centers of power the ability to permanently change institutions of government that frame policy making (Bowler and Donovan, 2008, p. 148).

Potential Factors that Influence Changes in PAS Policy

The four theories of political process presented give a better understanding of how policies change and are made, but they also show factors that may influence the policy process including the opinion of the elites, advocacy groups, demographics, windows of opportunity, and focusing events. The initiative as a direct democratic method has also been presented to show how citizens participate politically and change policy.

Using some of the factors that may influence policy from the theories as a guide, six specific factors have been selected for this study that are either external, internal, or policy specific to determine how citizens used the initiative process to influence physician assisted suicide policy in each state. These factors include governor influence, interest group influence, political culture, religion, ages, and gender.

The next section gives a brief description of each of the variables and how they are relevant to physician assisted suicide.

Governor Influence

Gubernatorial power is an important factor in the comparative analysis of state politics. There are numerous elements that help define gubernatorial power as well as different ways to think about the power each governor possesses. The governor of each state has executive powers and plays many different roles. For example, the governor may be the chief of legislation and negotiation, chief executive, leader of the party, opinion leader, and manager of crisis. Many view the governor according to the formal and informal powers that he/she has. The state constitution and laws outline the formal powers of the governor, whereas the informal powers are derived from tradition and the capabilities of the governor (Dometrius, 1999, p. 55). Informal powers often determine whether a state will have a strong or weak governor. Governors must be able to effectively communicate with a wide variety of political actors. They must be able to build coalitions and obtain party support. Ultimately, this determines the extent to which they are able to achieve their legislative goals.

As chief legislator, the governor initiates some legislative programs for the state. In this role, governors act as the "initiator" of public policy decision. As party leader, traditionally, the governor was the head of their state's party, but things have changed. Governors actually have no formal disciplinary powers over members of the own party, but within the legislature, parties still matter (Dye and MacManus, 2003, pp. 219-220). Partisanship in and of the legislature is important because governors usually get more support for their programs from members of the governor's party. As chief negotiator, the governor is responsible for negotiating with other governments, local, federal, and international. As opinion leader, governors are leaders of public opinion in their states.

Governors are very visible and have the ability to focus public opinion on issues that are of importance to them. As crisis manager, governors may be called upon in times for crises. A crisis may include a hurricane, school shooting, drought, or any major disaster that affects the citizens.

Of the many the elements that help define gubernatorial power, the two most significant are probably personal/informal power and institutional power. The institutional powers are also known as the formal powers of governors. These are the powers that come with the office and include the powers given by the constitution, by state statues, and by the state's citizens when they vote on referenda. There are several factors which comprise institutional powers and the most significant include the governor's potential for tenure, the ability to appoint, budgetary power, the ability to veto, and party control. At the state level, there are a number of elected executive officials and this division of power often serves to decrease the governor's institutional power. Each state is different, but examples of elected executive officials include the Attorney General, the Lieutenant Governor, and the Secretary of State. The governor must work with these and other elected officials who have similar claims to constituency throughout the state. Additionally, the Governor does not have the liberty to appoint most of his or her cabinet level officials and must work with numerous boards and commissions (Dye and MacManus, 2003, p. 234). Another element of institutional power involves tenure potential. Stated simply, governors have more power if they have the opportunity of staying in the position longer. Complex programs involving significant resources often die during the transition between governors. Another element involves the executive budget. When governors are placed in charge of this process, it makes them the chief lobbyists for the budget within the legislature and provides a significant amount of power to the executive branch (Dye and MacManus, 2003, p. 235). Veto power is probably the most direct element of institutional power that the state governor can exercise. In all except eight states, governors enjoy line item veto or executive amendment authority. This is a significant element of power available to the state-level executive branch and not available to the President.

Finally, partisanship is a significant variable that is the key to the governor's relationship and his power with regard to the legislature. Often, a different party controls the legislature and cooperation must be the style of their relationship if any degree of success is desired (Beyle, 1999, pp. 210-217).

As stated, personal or informal powers are ignored when focus is only placed on institutional powers. Personal powers consists of how the Governor leads the people, if he/she has a strong rating of approval, or if there has been success with the electorate. Institutional and informal powers coincide because together they help ensure the success of each governor. With regard to personal power, each individual has personal attributes that may either be considered a strength or a weakness. Thad Beyle (1999) suggests the four most important elements that help define personal power are electoral mandate, position on the state's political ambition ladder, the personal future of governors as governors, and performance ratings. Electoral mandate involves the margin by which the candidate won. If the victory was overwhelming, then the candidate will have significantly more power. The position of governor is often a stepping stone to higher levels. For example, Governors, Clinton and Bush continued their political ambitions and became Presidents of the US.

Obviously, if a governor possesses a significant amount of political ambition, then it follows that the individual would be expected to possess and achieve more power while serving at the state level. With regard to the political future of governors, those who are at the beginning of their terms have more power than those who are lame ducks and at the end of their terms. Finally, performance is another significant aspect of the personal power of governors. The measurement of this factor is related to whether the governor has achieved some level of success with regard to economic development efforts and another factor involves comparisons with his or her predecessors (Beyle, 1999, pp. 205-208).

Governors are able to influence public opinion when the governor combines institutional and personal powers. More specifically, when the governor is charismatic, persuasive, a seemingly good decision maker who has the constituents' best interest at heart, and follows guidelines set forth by the constitution, his/her influence is increased. When governors are influential, the issues they endorse help shape public opinion and helps ensure their electoral success. In a study that examined the effects of ballot proposition support on gubernatorial election outcomes, results showed that voting for winning initiatives helped determine those candidates that would win the election (Bucy and Ensley, 2006). In essence, when governors endorsed initiatives that won, the governor also won the election, thus increasing his/her ability to influence public opinion.

An article published by Lee Bernick in the Journal of Politics examines the powers of the governor. The author indicates that most of the interest with regard to gubernatorial power is focused on the governor's primary task, chief legislator. It is a common assumption that the success of a governor is dependent upon the ability to use all of the powers at his or her disposal. Although the Schlesinger index addresses four formal areas (tenure, veto, appointment, and budget), there is little other systematic data available to make generalizations concerning a governor's use of power to achieve success in the legislative process.

Bernick (1979) suggests the primary sources of data do not address the more informal powers that may strengthen the governor's position with regard to lawmakers. These informal powers include: popular support, mass media, prestige, personal conference with legislators, party leader, personal characteristics, public relations, and bargaining skill. Throughout his article, Bernick contends that informal powers are often the most important resources available to the governor and chief executive of the state (Bernick, 1979, pp. 656-660).

Governor Influence and Physician Assisted Suicide

Chief Legislator is one of the main roles that the governor of any state plays. In this role, governors can cast their role of the "initiator" of public policy decisions and help with setting the agenda. The governor's agenda, which is outlined in the annual State of the State address, gives a window to the legislative hearings. Often the issues discussed in the governor's address are the issues that are considered and debated among legislators. The governor's address draws attention from citizens and the media. The address gives meaning to the new legislative term. The governorship is multidimensional, and the governor works with numerous people to develop legislative proposals.

Added to the many roles of governors should be chief "convincer" since the governor can not directly introduce legislation, but has to convince legislators to sponsor proposed legislation for him/her.

Physician assisted suicide is one such policy decision that governors have weighed in on. For example, in 1998, a bill making the assistance of suicide a felony was proposed by Senator William VanRegenmorter and approved by Governor John Engler and enacted by the Michigan legislature. Under the law, if a person violated assisting someone in suicide, he/she could receive a $10,000 fine and be imprisoned for 5 years. Any person convicted of helping a person end their life would be charged with a felony. Engler stated that the legislation was important because "It gives prosecutors the tools they need to convict those who assist someone in ending their life. And it will put out of business those who prey on the vulnerable" (The Pro-Life Infonet, 2007). Currently, Booth Gardner, Governor of Washington from 1985-1993, who suffers from Parkinson's disease, is an advocate of assisted suicide. Washington was unsuccessful in legalizing physician assisted suicide during Gardner's two terms as Governor of the state, but he has promised to spearhead a campaign to pass an assisted dying law in Washington state similar to Oregon's Death with Dignity. Gardner hopes to have an initiative appear on the 2008 statewide ballot in Washington.

Though governors have considerable power as chief executive of the state, the power to work harmoniously with key state officials and the ability to affect public opinion are probably most important for this study. Without the ability to work with officials and influence public opinion, policies that the governor supports are more difficult to make. It is the governor's job to get along as best he/she can with state officials to make, working with them to policies that are in the best interest of their constituency. Citizens and/or interest groups have influence on the policy-making process and most often they will not support policies they do not agree with or are not in their best interest.

Interest Group Influence

Interest group influence is a second important factor in the comparative analysis of state politics. An interest group is a collection of individuals who share similar values and interests and seeks to influence policy so that it favors those shared interests (Gray and Hanson, 2004, p. 102). Interest groups' tasks may include researching, educating citizens and legislators, and seeking to influence legislation. Few aspects of American politics, including state politics, generate a more negative reaction from the public than do interest groups and the lobbyists who represent them. Yet Americans join interest groups by tens of millions (Gray and Hanson, 2004, p. 100).

Theories of Interest group power operate under the premise that varied interests compete to gain influence and control over public policy. In this case, pluralist theory sees competition as important because it brings stability and develops an efficient and effective government that is responsive to the people. Supporters of the theory include James Madison, Alexis de Tocqueville, Robert Dahl and David Truman.

Interest groups gained significance through the writings of David Truman and Robert Dahl in the 1950s and 1960s. Truman, in *The Governmental Process* (1951), discussed "institutionalized groups". He believed that "institutionalized groups" are stable and maintain themselves in relative equilibrium for long periods of time. When the equilibrium of a group is disturbed, different types of behavior occur. Disturbances can be caused by an event or occurrence such as catastrophic storm or the decrease of benefits. A change in behavior might manifest as an increase in group activities or the formation of a new group. An example would be Merian's Friends running an initiative campaign to legalize PAS after Dr. Kevorkian killed Janet Adkins.

If the disturbance in equilibrium is not too disruptive, the group's leader normally makes an attempt to restore balance (Truman, 1993, p. 30). Accepted examples of institutionalized groups include the courts, legislatures, executives, families, churches, and organized markets (Truman, 1993, p. 26). When these groups complete for limited resources, they are defined as "interests groups". These groups can only have a limited impact on government because any influence of one group is checked by another group's influence (Gray and Lowery, 1999, p. 260). Political scientists such as E.E. Schattschneider and Theodore Lowi challenged Truman's beliefs on interests groups. They argued that interests systems are "only weakly organized for contention over policy and that legislative committees organize the work of lawmaking in such a way that most interests are rewarded with specific benefits without competing with each other" (Gray and Lowery, 1999, p. 260).

There are several types of interest groups. Private interest groups act on behalf of those in private enterprise. They are powerful and spend the most money. Labor unions protect workers' interests. Professional associations represent the professionals in society. Public interest groups act on behalf of consumers and the general public. Interest groups and the ways they impact policy in American politics have increased in recent years. Thomas and Hrbenar identified the major factors that shape these systems (Thomas and Hrbenar, 2004, p. 107).

The socioeconomic and political environment of a state shapes interest group systems, and differences in this environment produce variations in group system development and operation.

There are five major factors affecting the influence of interest groups in the American state (Thomas and Hrbenar, 2004, pp. 108-109): Available Resources and Extent of Socio-economic Diversity- The more resources available and the greater the level of social development and social and demographic diversity, the wider the range or diversity of groups. State Political Environment- Political attitudes influence the types and extent of policies pursued; strength/weakness of political parties; the level of integration/fragmentation of the policy-making process; what are and what are not acceptable influence or "lobbying" techniques; and the general context in which interest groups will operate and the attitudes toward them. Governmental Institutional Capacity- State policy domain will determine which interests will attempt to affect state policy. Intergovernmental and External Influences- The distribution of intergovernmental spending and policy authority refers to the policies exercised and the amount of money spent by state governments versus policies and spending by federal and local governments. Short-term State Policy-making Environment- Changes in party control of government, in either the legislative or executive branch, especially when this is accompanied by party and/or caucus and/or ideological cohesiveness, can affect the access and effectiveness of certain groups of interests.

Interest groups are often created when a major event happens and individuals unite to encourage or stop change. These united individuals need a leader. The leader is usually a policy entrepreneur like Jack Kevorkian or Derek Humphry, who both publicly advocated assisted suicide. Several variables can be used to help outline why interest groups are created. One, major changes in the economy occur (Truman, 1993, p. 67). Two, changes in public policy occur.

When policies are created, the benefits of certain populations can be threatened certain programs available to the public inadvertently create groups who want to make sure their benefits are secured. For example, veterans want their military benefits secured so they have developed interest groups to help aid in this process. Three, various movements occur. As the assisted suicide debate has heated up over the past few years, the number of interest groups have grown and will continue to grow as the debate to legalize assisted suicide continues.

Interest groups gain power and influence in several ways. One, their size, and more specifically the number of members in the group, increases their power. As the old adage goes, "there is strength in numbers." Two, groups increase their power because of their wealth. Money is needed for ads, organizational costs and lobbying efforts. Three, interest groups increase their power because they have access to decision makers (Dye and MacManus, 2003, p. 122).

Interest groups vary in impact and influence. Much of this variance is impacted by change in the external environment. In essence, their influence changes as circumstances in the state change (Thomas and Hrbenar, 2004, p. 122). For example, many interest groups have been formed seeking to influence PAS policy in their state as a result of modern technology advancing and keeping people who are terminally ill or in unbearable pain alive longer than they wish to live.

Interest Group Influence and Physician Assisted Suicide

Rita Marker, a lawyer, has studied the funding of groups who approve of the right to die movement in the US. Marker believes that the groups are successful in bringing about change because of their vast wealth and resources (Ward, 2006).

In the 1980's and 1990's, some physicians had different thoughts about working with older patients, those who had some type of disability, and those diagnosed with a terminal disease. Physicians began to discuss their concerns publicly. For example, Dr. Ronald Cranford felt it was appropriate to approve of assisted suicide by physicians and chose to speak freely about his choice. Articles appeared in medical journals in support of assisting suicide (Ward, 2006). As noted often, Dr. Jack Kevorkian, a physician from Michigan, killed people through injection. The Hemlock Society's book, *Final Exit,* detailed methods of how people could kill themselves. Many in the medical profession believe that assisted suicide is valid and does have its place. Though the number of physicians who support assisted suicide has grown, not all physicians and medical professionals support legalizing assisted suicide. Groups such as the American Medical Association and the American Nurses' Association do not approve of legalizing assisted suicide, but they are aware that the process may be needed in some form when dealing with those who have terminal illnesses (Drickamer, Lee, and Ganzini, 1997, p. 146). As many argue, physicians and those in the medical profession have the responsibility of healing patients and saving lives. In theory, physician assisted suicide goes against the very foundation of the medical profession and is in direct violation of the Hippocratic Oath.

Euthanasia proponent groups have formed and constantly attempt to influence policy changes. Interest groups that approve of and seek to have the process legalized include, but are not limited to, Compassion in Dying Federation (of America), Death with Dignity Education Center, the Hemlock Society, Californians Against Human Suffering, and Partnership for Caring, Physicians for Yes on Initiative 119, The Northwest AIDS Foundation, Social workers in Home Care, and The Washington State Society for Clinical Social Work. (See Appendix B for Chronology of Voluntary Euthanasia and Physician Assisted Suicide)

Interest groups have been important to the policymaking process, but their importance has varied over time since they became an accepted part of the political process. They have gained influence in the physician assisted suicide movement through organized activity and their ability to affect public opinion through these activities.

Political Culture

Political culture is a third important factor in the comparative analysis of state politics. Daniel Elazar (1984) studied on how state political cultures have shaped the operations of state political systems. Political culture is the essence of what we value as citizens in the United States. These values are shared by others in society and help determine our thoughts about political life. Values define the acceptable or important issues and goals. Because political culture is based on values, it helps to shape the topics citizens debate and issues they seek to change. These issues may include immigration, crime, the death penalty, physician assisted suicide, and same-sex marriage.

There are different political cultures or subcultures within each state. These cultures at times have differing values and beliefs which cause conflict. Although there are differences between the states and conflicts occur, overall conflict is limited because the United States has a wide range of values that each state shares. Most of our conflicts occur because we disagree on how these values should be implemented, not because of the values or beliefs in and of themselves. For example, in regard to the assisted suicide movement, most share the belief that humans should not suffer unnecessarily. Physician assisted suicide would be one way to end the suffering of those who have intractable or unbearable pain, but many disagree on whether or not legalizing suicide is the most effective method of achieving this goal.

Daniel Elazar believes that there is a basic political culture in the United States as well as several subcultures within this basic culture. These cultures are important because they have clear political implications for how citizens feel and vote concerning physician assisted suicide. These subcultures are categorized as individualist, moralist, and traditionalist (Elazar, 1984, p. 114). The market place is the focus of the individualist subculture. Demands from the public help determine the actions of political actors. In the individualist culture there is a concern for self, party competition is very strong, and many politicians do not have the citizens' best interest foremost in their minds. In the moralist culture commonwealth is the basis for democratic government (Elazar, 1984, p. 117). The best interest of the citizens is at the heart of the government's actions. Citizens' lives are made better because of government, and the citizen is the main political actor in the moralist culture. Politics is a great activity of humanity when trying to find what is best for society (Elazar, 1984, p. 117).

Finally, the traditionalist culture accepts the government that is limited to the maintenance of the existing social and economic hierarchy. Family ties and social status are very important in the traditionalist culture. Those with power are usually the ones that come from wealth. Ordinary citizens are not expected to vote because they do not have a specific role in politics. Political parties are not very important in a traditionalist culture because they conflict with an elite-oriented political order (Elazar, 1984, p. 119). Some states have mixed political cultures. This means that there is a synthesis of two separate subcultures in the community in which one culture is more dominant than the other (Elazar, 1984, p. 125).

In 1969, Ira Sharkansky used Elazar's work to develop a nine-point categorization of political culture. Sharkansky's scale took the average of the regional political cultures within each state and gave each one a numeric variable to identify the type of culture in each state. Sharkansky and Elazar's work, when used together, gives a way to comparatively study the political culture of states.

Other researchers have investigated Elazar's thesis and/or used Sharkansky's scale. For example, Fitzpatrick and Hero (1988) confirmed many of Elazar's hypotheses. They found that moralist states have a stronger competition between parties than in other types of states. They also found that moralist states have greater use of their merit systems, and they have greater economic equality and policy innovation than other types of states (Fitzpatrick and Hero, 1988, p. 151).

Hero and Tolbert (1996) studied culture by examining how racial and ethnic affects policy outcomes. In their research Hero and Tolbert used an index of minority diversity and white ethnic diversity to develop measures for racial/ethnic diversity.

Their measures are compared with political culture categories using descriptive and inferential statistics, and they used regression analysis to examine how racial/ethnic diversity is related to educational, social, and “Official English” policies (Hero and Tolbert, 1996, p. 851). According to Hero and Tolbert (1996), “Elazar attributes political processes and outcomes to dominant or predominant cultural values and related normative tenets” (p. 853). These values come from a state’s dominant ethnic and religious groups (Hero and Tolbert, 1996, p. 853). Hero and Tolbert considered the values and beliefs of minorities lacking in Elazar’s work. They found that racial/ethnic diversity helps to explain a lot of the variation in the grouping of state political cultures. More specifically, they found that lower social policy outcomes and education are present when minority diversity (bifurcation) is higher in an area. This means that overall in racially diverse states, citizens had lower levels of education and social policy outcomes that were not favorable to minorities. Policies in homogeneous states for minorities are lacking when each race is examined individually. This research is significant because looking at ethnicity and diversity can help explain the variances in policies for all races and help determine factors that influence policy outcomes.

Rodney Hero in *Faces of Inequality* (1998) also studied culture and more specifically social diversity. The findings for his study are very similar to the one conducted with Caroline Tolbert. He believes that according to the social diversity perspective, state policy and politics which includes political culture can be attributed to racial and ethnic diversity (Hero, 1998, p. 9). Hero believes that Elazar’s framework is limited, and even though his framework parallels Elazar’s, there are some departures.

Hero’s categories of homogeneity, heterogeneity, and bifurcation are clearer, more precise, and accounts for change better (Hero, 1998, p. 10). Hero’s framework takes into account that context matters because “racial/ethnic diversity contexts help determines the beliefs, attitudes, and ideologies of individuals and groups associated with the political culture thesis” (Hero, 1998, p. 10).

Political Culture and Physician Assisted Suicide

Daniel Elazar defined political culture as “the particular pattern of orientation to political action in which each political system is imbedded” (Elazar, 1984, p. 109)**.** Political culture guides how we view government and how citizens govern themselves within the political arena, creating a basic guide for facilitating political change. Political culture is grounded in values, thoughts about what is acceptable and important. For policies on the legalization of assisted suicide, individual freedom is the value that guides decision-making on this policy. Some would refer to it as individualism, and some even refer to it as independence. All individuals have a certain amount of autonomy and control over their lives; these basic rights have been outlined in the United States Constitution.

The physician assisted suicide debate in Washington, California, Oregon, Michigan, Maine and other states reflects interpretation and the extent to which this freedom extends individual freedom. For many, the right to seek assistance with ending their lives is about individual choice. Parameters are definitely in place to keep order in society and prevent abuses, but many who suffer terminal illnesses are not always able to appreciate these parameters.

Many terminally ill patients value human life, but feel that only they know what it feels like to suffer from unmanageable pain. Individuals want to know that if they so choose, they have the right to end their suffering by committing suicide.

Public opinion on physician assisted suicide is mixed (Blendon, Szalay, Knox, 1992, pp. 2658-62). Opinion polls show that at least two thirds of the population favors some form of physician assisted suicide (Bachman et al, 1996, p. 303). In the early 1990s, Washington and California tried to pass legalize physician assisted suicide through initiatives, but were not successful. Oregon sought to pass legislation in 1994, and was successful. Measure 16 passed in Oregon with the 51% approval. Over all, national polls show that despite physician assisted suicide being legalized only in Oregon, many Americans support legalizing suicide. They feel that citizens have the right to control what happens to their body as well as a right to die with dignity. The Harris polls showed that approval for active voluntary euthanasia grew from 37% in 1973 to 61% in 1985. The Roper Polls showed approval for voluntary active euthanasia grew from 62% to 64% in 1990. Another polled conducted by Gallup in 1996 found that over 70% of people thought those who were terminally ill, should have the right to choose assisted suicide. A study in the New England Journal of Medicine of physicians of AIDS patients discovered that over 50% of physicians had helped a patient commit suicide at least once, if not more. An Oregon survey conducted in 1995 discovered that even though 60 % of physicians would not assist a patient with committing suicide, they felt some form of the practice should be available to patients (Emanuel et al, 1996, pp. 1805-10). Results from the various polls seem to show that physicians are more supportive of aiding in assisted suicide than other forms of euthanasia.

The government's role as it relates to physician assisted suicide varies. Advocates feel that it is the physician and patient's responsibility to decide on assisted suicide. One's decision to end his/her life should not be a concern of the government; however, others feel that the government has a legitimate right to intervene for the good of society. What is significant when examining culture is how citizens have allowed their values to shape their thoughts on death and their right to choose, but also on how they should directly participate in government to protect their rights.

Religion

Culture, public opinions and are also influenced by religion. In the United States, there is a long history constitutional and judicial of separation of the church and state. In spite of this, politics and religion are often combined. People's core beliefs about how others should be treated are often defined by their religion. Movements and debates in the United States from civil rights to abortion to same sex marriage and to physician assisted suicide have all used religious beliefs as a basis for support and authority.

There has always been some controversy as to the role religion should play in American government. In the First Amendment of the U.S. Constitution, the government is charged with making sure that all have the right to practice their religion without the promotion or institutionalization of a particular religion or church. James Madison felt that combining religion and politics could be problematic. In his famous *Federalist No. 10* he wrote: "A zeal for different opinions concerning religion have, in turn, divided mankind into parties, inflamed them with mutual animosity, and rendered them much more disposed to vex and oppress each other than to co-operate for their common good."

Many Americans support religion and believe that it has an impact on public life, but they are divided on the amount of impact religion is having on government and politics. According to Pew Research Center, in 2006 over 50% of citizens believed that the impact if religion on public life and politics is decreasing. Those who hold this view support religion's role in public life. From the Pew Research survey conducted in 2006, 67% of those surveyed viewed the dominate religion in the US as Christian. This figure has increased from past research results.

Research has also uncovered demographical differences on how citizens see religion and politics. More whites and blacks feel that citizens should have more control over legislation than religion, whereas more women feel that religion should have more control over legislation than men. Those who are younger and have more formal education share the same sentiment of blacks and whites, that citizens should have more control than religion.

Those that feel citizens should have more control must realize that religion will always have an impact on politics because citizens are members of society and religious groups. It is unrealistic to think that citizens will separate their religious views when they are participating in politics. Many citizens' values are generated by and enforced through their religious faith, and in turn, they allow this faith to guide their decisions as they vote and participate in politics.

Religion and Physician Assisted Suicide

Regardless of the separation of church and state, religion still has a major influence on politics. This influence can be seen in the current debate in America on physician assisted suicide and the right to die. According to Richard E. Coleson (1996), in assessing contemporary religious views on suicide and the related subjects of euthanasia and assisted suicide, knowing both what various religious organizations believe and what percentage of the population identifies with each organization is useful. In the United States, an overwhelming majority, 86.2%, are Christian. Beyond this, 1.8% are Jewish, 0.3% are Muslim, 0.3% are Unitarian Universalist, 0.2% are Buddhist, 0.1% are Hindu. The remainder is Native American, Scientologist, Baha'i, Taoist, New Age, Ekantar, Rastafarian, Sikh, Wiccan, Shintoist, Deity, and other unclassified religious adherents.

Most religions deal with death. One important way religion deals with death is by seeking to explain it. Death is an experience that we all must have, and, if religion can provide some type of understanding of death, people seem more willing to accept and make peace with the dying process. Patients who may be terminally ill or their families may also find solace in their religion.

Two basic points are made when debating end of life issues religiously. One point is that some prefer autonomy in deciding life and death (Burdette, Hill, and Moulton, 2005, p. 80). With this point, individual rights are highlighted. Supporters believe that all people have God granted choices, even in issues of death. The other point is that some want God to "absolute dominion" in life and death issues (Burdette, Hill, and Moulton, 2005, p. 80). They argue that God has the authority to decide when a person is born and when that person will die.

Suicide is prohibited in almost all religions. Many believe that God gives life as a present, and life is to be treasured. Suicide is prohibited by Christians, Jews, Catholics, Protestants, Buddhists, and Muslims. In cases such as euthanasia there are still loopholes. Many religious scholars explain their own ways in such ethical dilemmas. Below are some of the basic views on suicide of two of the major religions in America.

Christian Perspective

Christianity is centered on the belief of the birth, life, teachings, death, and resurrection of that Jesus Christ. Christians comprise the largest religion in the world (Religion and Ethics, 2007).

Their foundation is the Bible. In Christianity, there are numerous thoughts about life, death and medical issues. According to the Christian faith, euthanasia and assisted suicide is wrong because it goes against biblical principles. In the bible, the sixth commandment from God states, “Thou shalt not kill.” This commandment is also depicted in several of their verses throughout the bible such as Luke 18:20 and Matthew 5:21. The Catholic Church’s position on assisted suicide also comes from these Biblical teachings. The Catholic position as enunciated by Pope John Paul stressed that true human freedom is realized not by giving a person the choice to kill themselves or others, but by understanding the value of human life (Religion and Ethics, 2007). In Genesis, 9:6, assisting a person with death means the killing of someone who was made in God’s image.

The different Protestant versions of Christianity are more mixed about their views on assisted suicide and euthanasia. Many Protestants who oppose the practice use Jesus' teachings against killing as a guide on how to govern themselves (Sherkat and Ellison, 1997). Liberal Protestants usually hold more tolerant views on wide variety of social and political issues (Roof and McKinney, 1987). The rights of individuals are very important in many liberal Protestant churches and individuals are given the autonomy to make decisions that are best for them (Larue, 1996). Some who support physician assisted suicide use the teachings of Joseph Fletcher, a humanist, as a guide. Fletcher argues for the legalization of euthanasia because he believes suffering and pain are purposeless, demoralizing, and degrading. He believes that personality and a person's dignity should be valued more than life. Additionally, he believes that even though Jesus stated, "Thou shalt not kill", he also stated "Blessed are the merciful". He believes that being merciful is no less important than not killing (Euthanasia, 2008).

The Presbyterian Church USA is an example of the liberal Protestants support of individual rights. The church encourages debate within the church and provides a guide to members informing them that there is "no neat resolution of these issues" and encouraging "participants with ambiguities, to respect one another's perspectives, and to model ways of effectively considering controversial topics" (Presbyterian Church USA 1995: ii).

Jewish Perspective

Jews do not permit the use of active euthanasia. They see the act as murder. Unmanageable or unbearable pain is of no consequence to those in the Jewish faith; the law still stands.

The Talmud - Smachot 1:1 says, “One who is in a dying condition is regarded as a living person in all respects”. Under the Jewish tradition, a person can give morphine to ease pain. For others, administering morphine in theory goes against Jewish traditions because too much morphine can slow down a person’s heart and kill him/her. In reality, the person giving the morphine will go without punishment because he/she administered the medicine trying to ease pain.

A person’s life under the Jewish faith, regardless of how old or the state of it always has value. For example, the life of a 90 year old with cancer is just as valuable as a person 25 years old that is perfectly healthy and should be preserved as best as possible.

Burdette, Hill, and Moulton (2005), found evidence that religion does have an impact on physician assisted suicide views. They found that conservative Protestants are more opposed to physician assisted suicide than non-affiliates. Moderate Protestants and Catholics also oppose physician assisted suicide more than non-affiliates (Burdette, Hill, Moulton, 2005, p. 90). Church attendance also helps to explain these attitudes towards physician assisted suicide. Those who religion is not a major part of their lives tend to support physician assisted suicide more; for those who say religion is important and attend church attendance often, support for physician assisted suicide less. So as church attendance increases support for PAS decreases.

Church attendance also affected the attitudes of blacks and whites as it relates to physician assisted suicide. Blacks tend to be less accepting of the practice than whites because of their affiliation with a religion and attendance in church.

Mainly all religions, regardless of their basics philosophical and/or foundational principles oppose physician assisted suicide, and many citizens allow religion to guide their thoughts on dying and how they vote on physician assisted suicide.

Age

States differ in the composition of their populations. States vary in the proportion of old people to young people, in the number of poor people, in the number of foreigners, and minorities. When populations are very diverse, there are major challenges to government. Conflict often arises as government tries to address so many diverse needs through policy (Gray, 2004, p. 10).

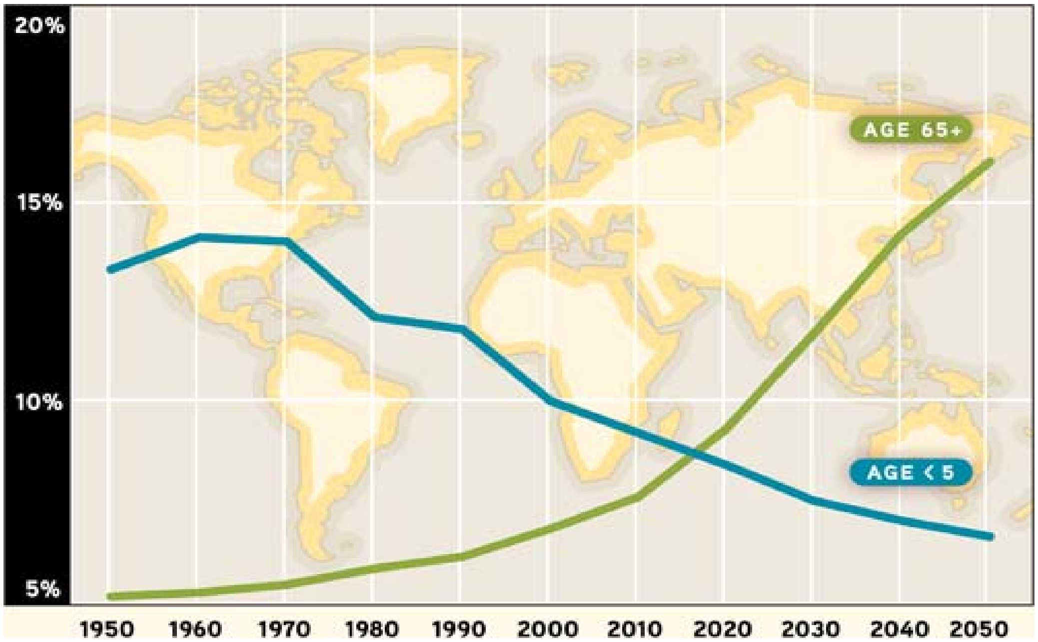
In states where there is a high percentage of older citizens, there is an increased demand for the number of nursing homes, doctors, mass transportation, and senior centers (Gray, 2004, p. 10). An older population also requires more support from the government by way of social security and Medicare. Their need for services often adversely affects a state's economy. Money is taken from other expenditures in the state's budget to cover the costs of services for seniors. However, having a large population of youths can also adversely affect a state's budget. In states that have a rapid growth, there is a high number of youth.

According to Hobbs and Stoops (2002), normally the southern and western states have more young people. When the population is filled with youth there is a demand for quality educational systems, day care centers, and various youth programs.

A 2007 study entitled, “Why Aging Maters: A Global Perspective”, reported that many people have a higher life expectancy and for some, their quality of life has improved. As it relates to government resources, this discovery is good and bad. People do not live for free. Citizens require service regardless of age. The only difference is the types of services needed by each age group. As citizens age, they impact the economy and legislation. States must be able to sufficiently provide for the elderly, and legislation is often created to ensure that they receive these services. Social security legislation was created as way of ensuring that all who are eligible for benefits receive them. Not only is the economy affected by those who age, but the children of those aging are affected. For example, as parents live longer, their adult children often become responsible for their care and must seek positions that accommodate schedules for properly caring for their parent/s. One way employers accommodate adult children is in the form of discretionary benefits. These types of benefits are usually the benefits that employers use in attracting the best and brightest employees. Day care benefits for children and the elderly are a part of discretionary benefits that many employers are giving because of the growing population of women in the workforce as well as the growing number of employees taking care of aging and ill health parents/relatives (Cayer, 2004, p. 73).

Table 2-1 shows that those 65 are living longer lives. They are beginning to be a larger population than toddlers and children under five years old. This growth is occurring not only in the US, but around the world.

Table 2-1



Source: United Nations Department of Economic and Social Affairs, Population Division. World Population Prospects. The 2004 Revision. New York: United Nations, 2005.

Dobriansky, Suzman, and Hodes (2007), along with other researchers and organizations, were able to identify some basic trends from the study on aging. They found evidence that people are living longer. As a result, life expectancy has increased, but how much it will increase is still unknown. Not only are people living longer, but those 85 and older have one of the fastest segments of growth. With the increase in the population, there is also an increase in illnesses. These illnesses are responsible for the deaths of many older citizens. As people age, families will change.

As previously mentioned, adult children will have to take care of aging and ill parents, and those without children will have to seek support from other relatives and/or government services. Ultimately, governments will have to restructure social service and entitlement programs because so many elderly people are eligible for services and benefits, and resources are limited. Will the elderly have limited benefits as a consequence of living longer or will the younger population have limited benefits to accommodate the older population?

Gender

Gender differences can also impact how citizens think about public policy. “Although we traditionally think of men as more engaged in politics, men and women have different ways of thinking about political interest” (Horner, 2006).

In her research, Horner studied people’s responses concerning public affairs and the government. The study was broken down into three parts: a “taste” for politics, which includes citizens who find politics interesting, enjoyable and legitimate; a sense of stake in political outcomes, which monitors what impacts politics have on an individual; and a desire for oversight of public officials, which entails accountability for elected officials and public affairs (Horner, 2006).

Horner found that gender affected “taste and stake”. Taste is very important for men, and it is one of the main reasons they participate in politics. Women on the other hand, find both “taste and stake” important as they decide how they will participate in politics (Horner, 2006).

Gender politics in the United States comes with successes and failures. For many years, males have dominated the workplace and political system. Through the feminist movement women have tried to level the playing field. What has worked well in the United States is the devising of organizations that have helped women to understand their common interests. To effectively bring change, women have to unify and work together. Women now have a better understanding of how to categorize problems that affect them. From this understanding, women have learned that all problems are not personal in nature, but can be resolved through the political system. As women have strived to solve their problems through the political system, they participate in politics and vote differently than men because some of their issues are not the same as their counterparts. This difference in participation and voting illustrates Horner's observation why "taste and stake" affects how women vote politically.

Though great strides have been made through the feminist movement, inequalities between men and women still exist. For example, men still tend to make more money than women even when doing a similar or the same job (Laine and Turner, 2004, pp. 238-240). Until things are completely equal between the two groups, differences in political participation and voting will continue.

Gender, Age and Physician Assisted Suicide

Gender and age matter as they relate to policy and more specifically physician assisted suicide policy. Men and women have different opinions on some policy issue such as abortion**.** There is also a difference of opinion between age groups.

However, the fact that a difference occurs is not as significant as how these differences actually affect policy. An example of age and gender differences can be seen in public opinion polls on physician assisted suicide. Otlowski (1997) reviewed the Gallup, Harris and Roper poll results concluded that “acceptance of active voluntary euthanasia has grown among all major population subgroups, but change has been greatest among Catholics and the younger age groups” (p. 261). Other religious groups or those that identify with a particular religion support assisted suicide even more than Catholics. Also, those who are younger tend to be more accepting of assisted suicide. Otlowski also found that conclusions could be made about education, race, and income. Fewer African Americans support assisted suicide than their counterparts from other races. Individuals with higher education and higher incomes are also more likely to support assisted suicide (Otlowski, 1997, pp. 259-261).

A 1993 Roper poll conducted found that 47% of those ages 18 to 29 approved of physician assisted suicide and 55% of those 60 and over did approve of physician assisted suicide. In another 1996 poll conducted for the Washington Post, results showed that half of the population support physician assisted suicide being legalized (Washington Post, 1996). Fifty-seven percent of people who where between the ages of 35 and 44 approved of physician assisted suicide being legalized. Forty-six percent of people 65 and over did approve of physician assisted suicide being legalized.

Differences of opinion in age and gender are important. Women tend to vote more than men even though men are more involved in politics. Likewise, those 65 and older tend to vote more than their younger counterparts. The economically impoverished and less educated are least likely to vote, feeling estranged from the voting process and politics (Leighley and Vedlitz, 1999, pp. 1092-114).

People can have opinions as seen in the polls, but if they do not utilize the necessary democratic tools such as voting or initiatives, their opinions are just that, opinions. Four models of the political process have been discussed that described how policy changes and factors that may influence this change. The initiative process was discussed as a tool available to citizens to directly change policy. Additionally, six factors were discussed to give a better understanding of the influences on PAS policy. Each factor is significant to the policy-making process. Governors are important because they are the chief executive of the state and have a major influence on public opinion which also influences which policy outcome. Interest groups are important because they are most often responsible for sponsoring and proposing initiatives to change policy. Interest groups also have access to the media and can impact public opinion through media time. Culture, religion, age, and gender are important because each of these factors shape what issues are relevant to citizens and how they feel about these issues. These factors are also important because they help guide how citizens vote and engage in politics. The next chapter describes the hypotheses and methodology designed to answer the study's research questions.

CHAPTER 3: METHODOLOGY

By comparing factors in Washington, California, Michigan, and Maine to those in Oregon, the research will attempt to answer a basic question: Why was Oregon successful in legalizing physician assisted suicide and Washington, California, Michigan, and Maine not? More specific questions for the study are outlined further in the methodology. Six factors including governor influence, interest group influence, culture, religion, age, and gender will be used to answer this question.

This research is conducted using mainly qualitative methods, but also quantitative methods. Most researchers use one or a combination of two approaches, quantitative or qualitative research. Qualitative research is descriptive and provides details. Quantitative research deals less with written detailed description and seeks to explain variances between variables using statistics. The ultimate goal is to explain the cause of variances as well as their effects. The main focus of qualitative research is on processes and outcomes. It is often inductive in nature because the researcher uses the details gathered from a study as a means of devising hypotheses and theories. It focuses on human behavior and seeks to understand why certain behaviors occur. It details descriptions of human characteristics, cases and settings. There are four essential features of qualitative research: the correct choice of appropriate methods and theories; the recognition and analysis of different perspectives; the researcher's reflection on their research as part of the process of knowledge production; and the variety of approaches and methods (Flick, 2006, p. 14). Because not all people are alike, researchers must take into account the different perspectives of a study's participants as a tool for understanding and analyzing the issue being studied. Researchers are very important in qualitative research because the subjectivity of the research and the study's participants are a part of the research process. The researcher's ideas, actions and/or thoughts become data for the study (Flick, 2006, p. 16). There are several different methods and approaches to qualitative research such as focus groups, ethnographical studies, and case studies. This research will use the case study method. Case study research is significant because it explains difficult phenomena and issues. Case studies are used when one wishes to garner details of how and why something may have happened. According to Robert Yin (2003), "case studies are the preferred strategy when how or why questions are being posed, when the investigator has little control over the events, and when the focus is on contemporary phenomenon within some real life context" (p. 13). This research seeks to understand the phenomena of physician assisted suicide, specifically, the influences that have led to the legalization of physician assisted in Oregon. A case study approach was chosen because it allowed greater insight into the various steps taken to legalize physician assisted suicide in the United States through direct democracy efforts. It also focuses on how the actors and demographics of each state have affected the outcome of legalizing assisted suicide.

American states and communities provide an excellent arena for applying comparative analysis. States are not alike in social and economic conditions, in politics and government, or in their public policies. However, states do share a democratic government, power with the national government and other states, and some of the same basic values. These differences will enable the researcher to search for and uncover relationships between different socioeconomic conditions, political system characteristics, and policy outcomes.

States have been called the "laboratories of democracy" for their innovations and state-specific policies/programs. If a state has a policy that is unique, effective and/or efficient, another state might study that state to adopt the policy in such a way that it might be beneficial for their state. For example, Oregon legalized physician assisted suicide through the initiative process. As a result, Washington, California, Michigan, and, Maine have also tried to legalize physician assisted suicide using the initiative process. Comparative analysis can also explain why a phenomenon occurs. The goal of conducting this comparative case study analysis is to identify commonalities and differences among each of the five states' efforts to legalize PAS to understand what specific variables contributed to the passage and/or failure of the initiatives.

Numerous researchers such as Robert Yin (2003), Helen Simons (2007), and Jennifer Platt (1992) have written about case studies and qualitative research. The basic steps detailing how to complete case study processes have been developed. The first step to conducting a case study entails determining and outlining research questions. The researcher should carefully delineate the topic being researched, what he or she wants to know about the topic, and why this topic is important. Developing questions will help the researcher keep a proper perspective throughout the research. A case study can analyze a person, technique, program, law or an agency and is often framed in a moral, political, and social context. It is imperative to conduct a thorough case study. A major part of conducting a thorough case study involves determining what research has already been written on the topic as well as allowing this research to guide the development of questions. Developing questions about the topic helps the researcher determine how to analyze any material gathered from the research.

Using the state of Oregon as an example and a point of comparison because of its success with legalizing physician assisted suicide, this research will attempt to answer several specific questions: 1) What factors contributed to Oregon's success and the defeat of the initiative in Washington, California, Michigan, and Maine? 2) Why did citizens use the initiative process to legalize PAS? 3) Who were key actors in the PAS movement? 4) What role did the governors, legislators, and interest groups play in the passage or failure of the initiative in each state? 5) Contextually, what role does state demographics play in PAS movement? In answering these questions, six aspects of each state will be analyzed: governor influence, interest group influence, state culture, religion, age, and gender.

The following section outlines theories found in the literature review about each variable. These theories will provide the basis for the six hypotheses created for this research.

Gubernatorial Influence

State governors, because of the position they hold and the institutional and personal powers that they possess in addition to their increased policy responsibility due to the ongoing devolution of policy from the federal government, play a key role in the policymaking process in the states (Goodman, 2007, p. 3). In all states, the governor is directly elected and in many states, has considerable power. For example, most can veto state bills. A state governor may give an annual State of the State Address to satisfy a constitutional stipulation that a governor must report annually on the state or condition of a U.S. state. The State of the State Address is the Governor's opportunity to formally influence the legislative process, specifically helping to set the agenda. Governors have the power and resources to orchestrate the building of coalitions and/or networks that are important to the consideration, development, adoption, implementation, and evaluation of state policy (Heclo, 1978).

Numerous factors may affect the Governor's legislative agenda and success. For example, a Governor needs to have a good rapport with legislators. It is also helpful if his or her party has control of one of the houses in the legislature, if not in both. Public interest groups should also be established quickly that support or oppose proposed legislation on the Governor's agenda.

As chief executive, the Governor has a lot of access to the citizens. Access to citizens may come from the Governor speaking at a conference, giving an interview, writing an article in the newspaper, speaking at a church service, or publicly endorsing a candidate running for office. With this access, the governor is able to give attention to proposed legislation as well as influence public opinion.

Based on this research, a hypothesis can be made. **Hypothesis 1: The greater the support and exertion of influence of the governor, the more likely his/her position on PAS is to pass.**

Data for information on the governor stances about PAS and activities will be gathered from each governor's State of the State Address during the year the initiative was proposed and from media stories about and/or media interviews with each governor. The stories interviews will be gathered from three of the top newspapers in each state. A content analysis will be conducted on each governor's speech and the stories/interviews to determine if each governor mentioned physician assisted suicide and how many times. Content analysis is used by researchers to see if a particular word, theme, phrase or concept is used in a particular text. Once the presence of the word, theme, phrase or concept has been identified in the text, the researcher then quantifies or counts the number of times that word may have been used. The researcher also examines the context in which the words were used and studies any relationships in the text to draw conclusions and inferences about use of these words. The goal for this study is to determine if the governor endorsed physician assisted suicide and if the initiative passed and to gain greater insight on the influence each governor exerted on the physician assisted suicide initiative process in each of the five states.

Interest Group Influence

The issue of whether to allow assistance when dying requires careful consideration from both those dying and from those providing assistance. For physician assisted suicide policy to be effective, a compromise from all stakeholders involved in the process must be reached. These stakeholders may include the patient and their family, physicians, organizations, and the courts. These stakeholders may also be known as PAS advocates/interest groups. Interest groups are a group of people who have a common goal and utilize various unified efforts to achieve the common goal. For example, Not Dead Yet, the Hemlock Society, the American Medical Association, Compassion in Dying, and the Anti-Euthanasia Taskforce are all interest groups who have tried to influence physician assisted suicide policy.

Research shows that interest groups are very influential to public policy. Pluralist Interest Group Theory assumes that there are numerous interests competing as a result of wanting to control public policy. Some theorists even believe that even though there are conflicts of interests, these interests can provide good government when balanced. In this case, how have interest group efforts and influence affected physician assisted suicide initiatives? This could be done by interacting with legislators, working with government agencies, and/or educating citizens on PAS. The power of interest groups comes from numerous places, including the size of a group's membership, the amount of money a group has, the type of leader(s) a group has, the group's mobility and flexibility, and the group's ability to contact policy actors and the mass media.

Probably most important to a group's power and influence is its ability to generate revenue and raise funds. Without money, groups are not able to undertake the causes they champion. A group's mobility is also a very important aspect of power and influence. Groups can mobilize by educating the public and group members. Informed citizens and members are better equipped to make informed decisions about issues concerning them. Groups can also mobilize by signing petitions and/or writing letters to the appropriate representatives. For example, numerous interest groups who sought to legalize physician assisted suicide through an initiative solicited the signatures from citizens on petitions. Additionally, the media is important for a group's power and influence. Interest groups purchase media time with funds they raise. The media helps interest groups because it gets the attention of voters, but also helps influence the legislative branch by giving attention to organizations and interest groups that seek government action.

For example, a law was created in Florida as a result of the media bringing attention to Terry Schiavo’s case. Her husband wanted to remove her feeding tube against her family’s wishes; as a result religious groups waged campaigns forcing action from the government on the state and national level.

Based on this research, a hypothesis can be made. **Hypothesis 2: The greater the support and exertion of influence of a state’s interest groups, the more likely their position on PAS is to pass.**

The amount of money raised and spent, the number of interest groups, and activities of interests groups involved in trying to influence the PAS initiatives will be gathered from the top 3 state newspapers and *Washington Post* and the *New York Times*, the Secretary of State’s Office, books on PAS, and PAS websites. This data will allow the researcher to identify the interest groups involved in the PAS battle in each state, the amount of money each interest group spent as well as strategies used to influence the PAS initiative process. Additional data will be gathered from a personal interview with 2 active interest groups in each state (one for and one against PAS) to determine the influence active interest groups had on the physician assisted suicide initiative process in each of the five states. Active interest groups for this study are defined as those groups who are for or against PAS, but also those who participated physically in influencing the initiative either by funding, seeking signatures on petition, working with the media, and or testified before legislators.

Each interest group will be contacted via phone and/or email to set up the interview. Contact information for each group will be gathered from their website. The interviews will be conducted via phone or email according to the preference of the interviewee. Each group will be asked the same structured questions.

Some questions for the interviews are as follows:

How was your organization formed? How did you become involved in the PAS battle?

Who are the leaders? Who are the members/groups involved in the coalition?

Did you support legalizing PAS? Why or why not?

What precipitated the fight to legalize or refute the legalization of PAS?

What were strategies you or your organization used to influence legislation?

What were the most significant challenges in supporting or fighting PAS?

Were you influenced by external organizations? i.e. churches, lobbyists, other interest groups, legislators

State/Political Culture

The conventional interpretation of the linkage between political culture and state public policy, popularized by Daniel Elazar, highlights the distinctiveness of mass political attitudes in moralistic, individualistic, and traditionalistic cultures.

Elazar believes that each culture provides a different interpretation of the purpose of political action and governmental policy. He defines political culture as “the particular pattern of orientation to political action in which each political system is embedded” (Elazar, 1984, p. 109). Even though Elazar defines three dominant cultures in the U.S., he asserts that political culture is dynamic and changes often. This change makes it difficult to define a pure type of culture. Change often occurs inside certain groups and as movement or change occurs, groups borrow culture from each other causing culture erosion and fusion (Elazar, 1984, p. 134).

Fitzpatrick and Hero found that the relevance of political culture to the political area is demonstrated in policy outcomes. For example, moralistic states usually have greater policy innovation and things are more equal economically among the citizens because the culture focuses on the community and not just individuals (Fitzpatrick and Hero, 1988, p. 151).

Hero and Tolbert believe that a state’s politics and policies are the product of the cooperation, competition, and or conflict between and among dominant and minority groups, not just between the dominant groups within a state as Elazar suggests. As a result, political processes and outcomes associated with specific political cultures often occur. For example, Hero and Tolbert explain in their research where Elazar’s political subcultures come from (Hero and Tolbert, 1996, p. 859). They found through the use of statistics that many heterogeneous states have an individualistic culture, homogeneous states have a moralistic culture, and bifurcated states have a traditionalist culture (Hero and Tolbert, 1996, p. 853).

Hero and Tolbert justify their groupings by explaining that in homogeneous states, partisanship is very strong for “policy relevant” issues and in heterogeneous states, political issues stem from less “policy relevant” issues. They note that many of the political processes and outcomes cannot be contributed completely to political culture because it is largely influenced by racial/ethnic diversity (Hero and Tolbert, 1996, p. 854).

In homogenous states even though high levels of competition are present including party competition, there is an underlying consensus that comes from homogeneity (Hero, 1998, p. 15). In heterogeneous states where there is more racial diversity there is a lot of competition and this competition is fostered by white ethnic and moderate-to-high minority diversity (Hero, 1998, p. 16). In bifurcated stated there is limited pluralism that historically emerges from legal and political constraints (Hero, 1998, p. 16).

Elazar’s and Hero and Tolbert’s frameworks are significant to this study because they theoretically offer a way to better understand the differences between states as well as diverse behaviors and basic orientations which include political participation, conceptions of the role of government in society, the role of interest groups and political parties, and deference to political elite (Erikson, McIver, and Wright, 1993, p. 152). By better understanding this diversity and these fundamental orientations, a greater perception of factors that may influence the policy process and policy outcomes may also be gained.

Based on this research, a hypothesis can be made. **Hypothesis 3: The more individualistic a state is, the more likely the initiative is to pass legalizing PAS.**

Data for this factor will be collected from Elazar's Indices of Political Culture of American States and from the researcher's assessment of Hero and Tolbert's racial/ethnic framework. Cultures of each state will be determined and how it impacted the physician assisted suicide initiative process for each of the five states.

Religion

Religious preferences translate into policy preferences. Those who have religious preferences tend to vote more conservatively on moral issues such as physician assisted suicide. Specifically, they tend to vote on issues that are aligned with their religious beliefs. If they believe that life is precious and to be preserved, they are not apt to vote in favor of abortion or physician assisted suicide which would end a life.

Pew research confirms that religion influences politics. More specifically, religiosity affects how one feels about issues such as physician assisted suicide. In a survey, Pew questioned how people felt about legalizing assisted suicide. In one question, respondents were asked how they felt about making it legal for doctors to "assist terminally ill patients in committing suicide," 43% were in favor of legislation while 48% were opposed.

In another question, respondents were asked how they felt about making it legal for doctors to "give terminally ill patients the means to end their lives," a majority of 54% gave its approval; 39% are opposed. While one notes differences probably arose because of the wording of the questions, religiosity also made a difference in how people responded.

Regular church goers and those that say religion plays an important role in their lives opposed legalizing physician assisted suicide, whereas those who are non religious supported legalizing PAS. Results showed that 72% of those who had little religious commitment supported allowing doctors to give terminally ill patients the means to end their lives; only 22% of the people are opposed. Pew also reported that only 32% of those with high levels of religious commitment supported assisted suicide compared to 61% in opposition.

Additionally, Pew found that Protestants and Catholics are more likely to not support physician assisted suicide than other religions, but Catholics tend to support the practice even less than Protestants.

Based on this research, a hypothesis can be made. **Hypothesis 4: The greater the number of Catholic and Protestants that vote differently in a state, the less likely the initiative is to pass to legalize PAS.**

Data for religion will be collected from available exit poll data from the states on Election Day. The data will be examined to determine the voting population of Catholics and Protestants and then determine how each population voted and if there was a difference.

Age

Research shows that age also influences perspectives on public policy. Age is important to public policy if for no other reason than the benefits that the aged receive. Benefits paid for social security, medical care, and survivors' benefits make up a major part of expenditures in the U.S. Although the aged may not have a general ideology that is common to all, they seem unified as it relates to issues pertaining to benefits (Pampel and Williamson, 1992, p. 7). The mobilization of the aged and their political influence has increased over the years. Interests groups of the aged have also increased, and as a result of these organizations fighting to politically to keep their benefits, they have been least affected by budget cuts (Pampel and Williamson, 1992, p. 7).

Age is also important to public policy because many people vote on issues that are important or relevant to them. How one perceives what is important or relevant to them and how they vote often depends on their age. For example, statistics have shown that older people are at a higher risk of chronic illnesses and terminal diseases, which would lead one to believe that the older a person is, the more relevant an issue like PAS becomes to them.

Studies have shown that citizens 60 and older vote more than their younger counterparts; however, when voting, those 60 and older tend to vote more conservatively.

Based on this research, a hypothesis can be made. **Hypothesis 5: The greater the number of voters 60 years and younger that vote differently from those 60 and older in a state, the more likely the initiative is to pass legalizing PAS.**

Data for age will be collected from exit poll data in each state on Election Day to determine the ages of the voting population and if there was a difference in how each age group voted.

Gender

Women and men participate and vote differently politically. Men participate more politically, but women vote more. Women tend to vote more conservatively whereas men tend to vote more liberally. There is no one explanation for the differences or political gap between men and women. However, Howell and Day (2000) conducted a study entitled "The Complexities of the Gender Gap". They found that explanations can be placed in two general categories: different life experiences of men and women and socio-psychological differences stemming from how men and women were socialized as children. From these sociological differences, men tend to focus on competition and individual rights whereas women focus less on individualism and more on relationships, caretaking and nurturing.

Physician assisted suicide is one such issue that may reflect different preferences of men and women. Many see physician assisted suicide as an individual choice. If men focus on individual rights more than women, they should support physician assisted suicide more than women.

Based on this research, a hypothesis can be made. **Hypothesis 6: The greater the number of males that vote differently than females in a state, the more likely the initiative is to pass legalizing PAS.**

Data for gender will be collected from exit poll data in each state on Election Day. The goal is to determine if men and women voted differently and if gender impacted the physician assisted suicide initiative process for each of the five states.

The second step to conducting a case study is designing the method for analyzing the data. When designing the method to analyze the data, the researcher needs to determine which cases are best for study and how to best gather the data on the selected cases. More than one case is often used in a study, but each case should be studied and examined individually. When making conclusions and reporting findings, the researcher can combine the findings to ensure the study is comprehensive. It is often necessary to use several different research tools to ensure the validity of the study. Research tools may include interviews, surveys, and public records. There are several types of validity. They include external and internal validity, construct validity, and reliability. When results are able to be generalized beyond specific cases of study, external validity exists (Yin, 2003, p. 34). It is the researcher's hope that by conducting research on physician assisted suicide initiatives; the results can be generalized to future states that might use the initiative to legalize physician assisted suicide. Internal validity is more causal in nature. It demonstrates that one event credibly leads to another event (Yin, 2003, p. 34). This study seeks to determine if the selected variables for this research impacted or caused physician assisted suicide initiatives to pass or fail. For example, the researcher wants to know if the governor's actions or statements on public opinion influenced voters to vote for or against legalizing physician assisted suicide. Each of the five governor's action and statements will be compared to determine possible influence. Construct validity ensures that whatever is being measured is measured accurately. This study must make sure that the variables, such as governor and interest group influence, state culture and state demographics, actually will determine why physician assisted suicide passed in Oregon and not in the other four states. When findings are accurate and can be repeated with the same results, they add reliability to a study. After this study is completed, anyone should be able to conduct the same study on physician assisted suicide initiatives and get the same results.

Another thing the researcher must be mindful of with validity and reliability is interpreting results and understanding each actor's perspective. Actors for this study include governors, legislators, and interest groups. Table 3-1 shows where data for each variable will be collected.

Table 3-1

Governor	**Culture**	**Age**
State of State Address	Elazar’s literature	Exit polls from CNN
Media articles/websites	Hero and Tolbert’s literature	
Interest Group	**Religion**	**Gender**
Secretary of State	Exit polls from CNN	Exit polls from CNN
News articles/ books/ websites		
Interviews		

The cases a researcher selects for study should reflect the researcher's focus. The research cases may be unique or they may be common cases that will aid in explaining the phenomena being studied. The cases for this research are unique because they involve states who have tried to legalize physician assisted suicide through direct democratic efforts. Washington, California, Oregon, Michigan, and Maine have all tried to legalize physician assisted suicide by using ballot initiatives. The states constitute the entire population for this study.

The third step to conducting a case study involves preparation of data collection. As most researchers find, data can accumulate quickly, forcing the researcher to lose the intended focus of the study. Data preparation is important to the case study method because it guides the study and allows the researcher to stay focused on the chosen topic of research. Pre-selected variables and research questions will help the researcher keep focus.

The fourth step to conducting a case study involves data collection. It is important to gather information in as orderly a fashion as possible to identify any similarities and consistencies (Yin, 2003, p. 97). By observing similarities and consistencies, explanations related to the issue can be discovered. Case study research is flexible, but when changes are made, they should be documented systematically.

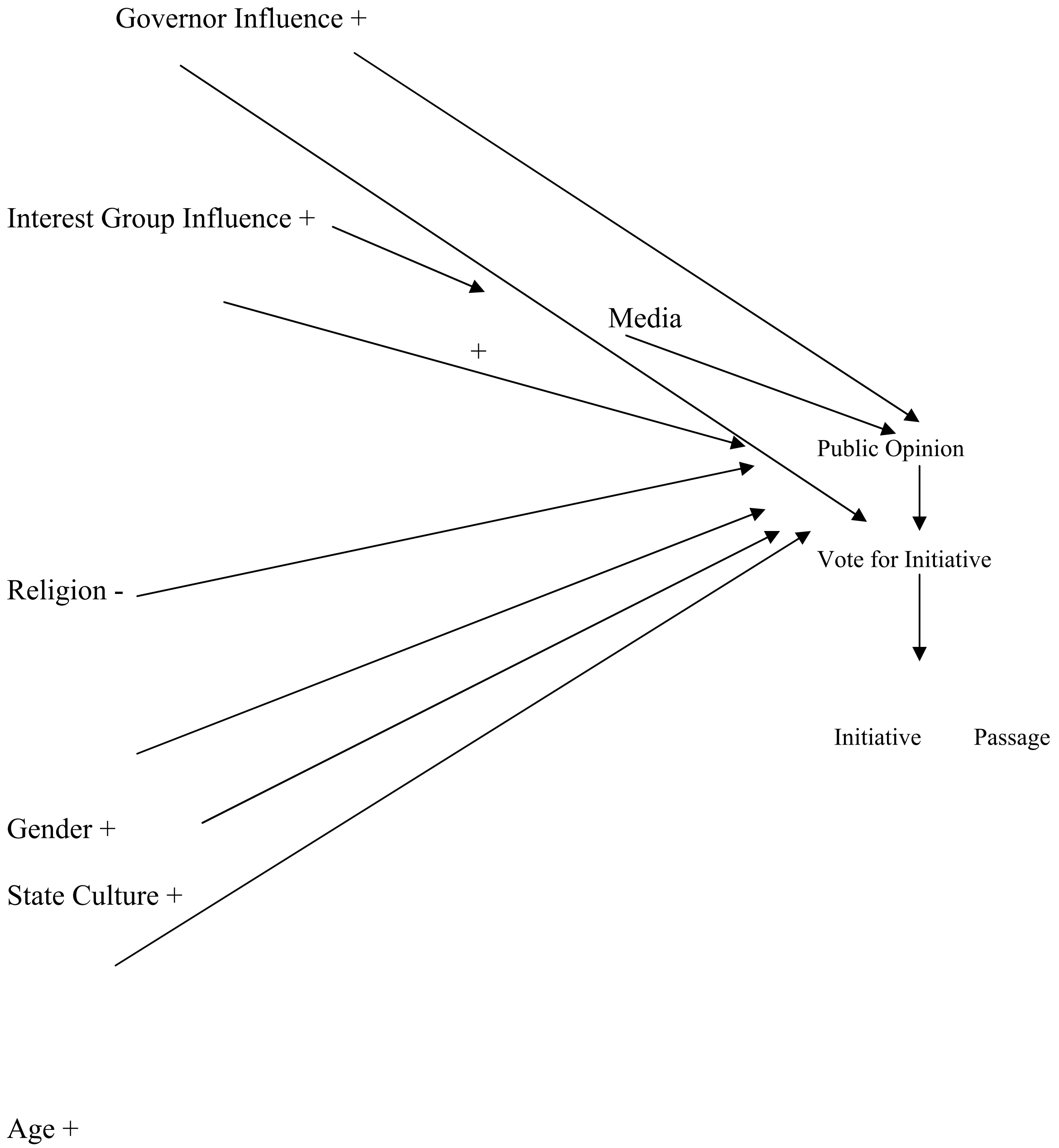
The fifth step to conducting a case study involves analyzing data. It is the researcher's job to look at any collected data and uncover possible relationships between the research issue and contributing factors. While uncovering these possible relationships, the researcher should be mindful of the original research questions.

Because multiple data collection methods are used with the case study data findings are strengthened, thus adding more reliability to the results of the research (Yin, 2003, p. 109). Multiple indicators will be used to analyze data collected on the five states. Governor influence, interest group influence, political culture, religion, age, and gender have been chosen as variables to help answer the research questions for this study. As previously stated, data on how citizens voted according to religion, age, and gender will be collected from state exit polls to determine voting differences. A Chi-square analysis will be conducted on the exit poll data to see if any statistical correlations are present. Statistical correlations help determine if an experiment's outcome is random or the result of a relationship between specific factors.

The sixth step to conducting a case study involves reporting. After completing the five previous steps of conducting a case study the researcher reports the data gathered. It is important that the researcher is able to report the data in such a manner that the data can be understood regardless of how difficult the issue or topic is. Chapter Four of this research are the case studies, which chronicle how each state tried to legalize PAS through the initiative process as well as what key factors aided or hindered the process. The research questions will ultimately guide how the story in Chapter Four unfolds and is presented. The findings will be analyzed and then a detailed report will be written explaining the findings and conclusions from the study. Suggestions for future study will also be included in the report.

The next chapter presents the case studies. Detailed accounts of the efforts to legalize physician assisted suicide in Washington, California, Oregon, Michigan, and Maine are discussed, the demographics of these five states are presented as well as information obtained in interviews with interest groups.

Path Diagram for Support for Physician Assisted Suicide



CHAPTER 4: CASE STUDY

Federalism describes a system in which the power to govern is constitutionally divided and shared between the national and state governments. In the past, the states have been held responsible for areas of health, education, morality, safety, and welfare. Since the 1950s when there were conflicts in these areas, citizens expected the national government to resolve the conflict (Dye and MacManus, 2003, pp. 63-64). Physician assisted suicide is a health and moral issue that the states are responsible for handling. But because there has been much debate concerning this issue, the Supreme Court has stepped in to try and resolve the issue.

On June 26, 1997 the Supreme Court made a unanimous decision stating that the Constitution upholds the right of a state to forbid assisted suicide. In Washington v. Glucksberg and Vacco v. Quill (see Appendix E) the Court held that Washington's prohibition against causing or aiding a suicide does not violate the Due Process Clause. The effect was to deny that the Constitution establishes a right to assistance in ending a person's life. One effect of the Court's decision is that new and more effective alternatives must be created to insure that people who are dying receive the best possible care.

If patients receive good and effective care, a desire to prematurely end their life would not arise because their lives are bearable or desirable. However, in cases where patients constantly suffer with no alternatives for better care, advocates of assisted suicide feel that the practice should be legalized.

Washington in 1991 and California in 1992 tried to legalize physician assisted suicide. However, neither of the attempts proved to be successful. Oregon passed legislation to legalize physician assisted suicide in 1994. Michigan in 1998 and Maine in 2000 also tried to legalize physician assisted suicide and were unsuccessful. What is so unique about Oregon that its physician assisted suicide initiative passed and the initiative in the other four states did not? A comparative analysis was conducted on the five states to answer this question. For each state in this chapter, the history of assisted suicide is detailed. A description of what each initiative would legalize is discussed, as well as how governors and interest groups influenced physician assisted suicide legislation. The political culture of each state in addition to demographics of each state is outlined. The goal is to offer a better understanding of factors that may have influenced physician assisted in the states.

Washington State – Initiative 119 (1991)

Washington's population is comprised of mainly whites. The state also has a large population of Asians, with African Americans having a lower population than Asians and Hispanics. Because of the state's racial composition, it is homogeneous. Homogeneous states have a very small minority population and a limited number of "white ethnics" such as non-northern and non-western whites (Hero and Tolbert, 1996, p. 853). Politically, Washington is a Democratic state that believes that the federal government should be active and compassionate. The political culture in Washington is moralistic which means that they consider government a necessary and legitimate tool for ensuring the good of society (Elazar, 1966, p. 97). Whether government and politics are good, is often measured by the level in which the government encourages the good for society and facilitates manifestation of that good. Physician assisted suicide has played an important role in Washington's moralistic culture. Government and citizens had to ask themselves, "Is legalizing physician assisted suicide in the best interest of society?"

Washington does not have a law that criminalizes suicide. However, it criminalized the practice of helping or causing the suicide of another person (Wekessar, 1995, p. 79). In 1979, Washington became the second state to pass a Natural Death Act, permitting persons to prepare an advance directive authorizing their physicians to withhold or with draw life sustaining procedures when death is imminent (Hillyard, 1999, p. 50). Citizens sought to change Washington's assisted suicide law by placing a measure on the ballot that would legalize assisted suicide.

In order to file an initiative in Washington, a copy of the proposed initiative must be submitted to the secretary of state by the sponsor. A signed affidavit of sponsorship verifying that the sponsor of the initiative is a legal voter of the state must be included in the file along with a $5.00 fee (Washington Secretary of State, 2008). Signatures are collected after the initiative has been filed and an official title for the initiative has been given. The required amount of signatures is determined by the total number of votes cast for the Governor during the previous Governor's election. In Washington, eight percent of that vote total is required for initiatives (Washington Secretary of State, 2008).

The president of the Hemlock Society wrote the initial draft of Initiative 119 (See Appendix H). The Washington legislatures forwarded the bill to the voters instead of passing the bill as it was originally intended in 1990 (Egan, 1990). The initiative would have changed the state's Natural Death Act by giving patients diagnosed with an incurable or an irreversible illness and only had six months to live the right to seek aid-in-dying through an advance directive. "Aid-in-dying" was defined as "aid in the form of a medical service that will end the life of a conscious and mentally competent, qualified patient in a dignified, painless, and humane manner, when requested voluntarily by the patient through a written directive at the time the medical service is to be provided" (Worsnop, 1995, p. 406). The request for help could have been stopped by the patient at anytime. The initiative would have also allowed a patient to be transferred to another facility or doctor if their current doctor or facility refused to aid in the patients' request to die (Nightingale Alliance, 2004). Washington Citizens for Death with Dignity sponsored the measure for allowing for either voluntary active euthanasia or assisted suicide if three conditions were met.

One, “aid in dying” must be voluntarily requested by the patient. Two, the patient must be competent. Three, the patient must be terminally ill, which meant that two physicians agreed that the patient would die within six months (Quill, 1993, p. 152).

Initially, Washington’s physician assisted suicide initiative was supported by 61% of voters and seemed like it would pass because of the state’s large percentage of religiously unaffiliated and liberal-minded voters (Worsnop, 1995, p. 407). Support for Initiative 119 decreased when voters were asked in a poll, “Should the law be changed to allow mentally competent but terminally ill persons to request a physician’s assistance in ending their life, when, in the opinion of two physicians, they will die within six months?” (Carson, 1991) Initiative 119 was supported by various religious, medical, and political organizations. The religious organizations included the United Church of Christ, The Unitarian Universalist Association, The National Council of Jewish Women and the Interfaith Clergy for Yes on Initiative 119 (Boyle, 1991). The medical organizations included Physicians for Yes on Initiative 119, The Northwest AIDS Foundation, Social workers in Home Care, and The Washington State Society for Clinical Social Work (Jacobs, 1993). The political organizations included the American Civil Liberties Union of Washington, The Puget Sound Council of Senior Citizens, and the Seattle-King County Bar Association, The National Organization for Women of Washington (Hillyard, 1999, p. 55). Proponents for Initiative 119 spent around $1,734,100 trying to legalize assisted suicide (Public Disclosure Commission, 2008).

The largest portion of the money spent went to educating citizens for $840,000. Over $600, 000 was spent on television ad campaigns, and the least amount of $100, 000 was spent on collecting signatures (Humphry, 1993, p. 96). The largest contributions came from groups like the Hemlock Society and other proponents of assisted suicides for the terminally ill. Don Parker, a man suffering from polio gave $35,000, the largest amount given by a single person to approve Initiative 119. In an interview, Parker said, "I think we have an exaggerated view of the value of life. They can keep a cadaver alive nowadays. I've lived 34 years in a nursing home and I've watched a lot of slow, painful deaths. People lose their dignity. They have to be diapered and force fed. Some can't chew or swallow their food. It's very expensive and terribly painful for people who would rather have the peace of dying" (*New York Times*, 1991).

In the campaign, many ads aired that to tried influence citizens to vote in favor of Initiative 119. Supporters' ads reflected the belief that terminally ill patients should have the right to choose when and how they die. Kathryn Tucker, a Seattle lawyer and co-author of the initiative, said the measure expanded a person's freedom of choice (*New York Times*, 1991). Supporters also tried to show some of the flaws of Washington's Natural Death Act. Ads sought to convey the fact that a living will did not always mean that a patient's desires would be followed. Even against their expressed will, patients could be given life sustaining treatment. In one ad, amid two people holding hands was an unresponsive man shown being kept alive by the life sustaining technology. Then a voice said, "This isn't what dad wanted, these machines. That's why he made a living will" (Hillyard and Dombrink, 2001, p. 51). The ad went on to explain that even though it was unknown by many, wills are not always honored in Washington, and patients' desires are often ignored.

It also explained that even though patients' desires are not always followed with a living will, Initiative 119 would allow for patients that are terminally ill with less than six months to live the opportunity to die as they chose (Carson, 1991, Gilmore, 1991).

There were some 20 groups that opposed physician assisted suicide that included groups such as Human Life of Washington, the Catholic Church, The Knights of Columbus, The Washington State Medical Association, the state Hospital Association, and other Christian organizations. This coalition of groups was named 119 Vote No! and was directed by Eileen Brown, a hospice nurse. These opponents spent approximately $1.9 million in their efforts to defeat Initiative 119 and Initiative 120 (Humphry and Clement, 1998, p. 220). Initiative 120 was a measure for the continued protection of abortion rights. Combining resources and groups that opposed both initiatives added strength to the opposition campaign. The Catholic organizations were extremely helpful in opposing these measures. They provided funding, generated additional revenue, put together registration for new voters, and provided absentee ballots (Carson, 1992, p. 9).

Ad campaigns for the opponents reflected their complaints about the measure's lack of safeguards. One ad stated, "Initiative 119 is being sold as a safe mercy killing law. But it has no safeguards" (Carson, 1992, p. 9). As a way to show the lack of safeguards an ad aired that said, "An eye doctor can put you to death" (Carson, 1992, p. 9). In another ad, William Mahoney gave his testimony. He said, "I was told four years ago that I only had two weeks to live.

Back then, I might have chosen to die, and I am thankful that such a law did not steal the life that doctors had misread. Initiative 119….it's more or less a right to kill" (Carson, 1992, p. 9). Additionally, opponents wanted to show some of the ambiguity present in Initiative 119. For example, even though the written initiative mentioned assisted suicide, it did not mention euthanasia (Humphry and Clement, 1998, p. 220). They used radio and television ads using Former Surgeon General C. Everett Koop as the group's spokesperson (Jacobs, 1993).

Opponents of the Death with Dignity Act felt that there was no protection for vulnerable groups such as the elderly, the indigent, and disabled against voluntary euthanasia. The initiative did not protect those who may be depressed by requiring them to have a psychological evaluation. There was no waiting period for a patient who wanted to end his or her life. For example, if the patient requested to be approved for assisted suicide and was approved today, he or she could terminate his or her life today. If the patient requested his or her life to be terminated with assistance from the physician, the physician was not required to contact the patient's family. Opponents felt that doctors are not completely sure as how long someone who has been deemed terminally ill has to live (Humphry, 1993, p. 95). Also, it was written to leave open the possibility that dying patients could receive a lethal injection. Initiative 119 was proposed as part of a three part amendment to the state's Living Will with a Directive to Physicians. With the amendments, assisted suicide would be allowed and patients would have the right to request the discontinuation of life sustaining treatment. Ultimately, opponents felt that there was an inherent hopelessness in the pro-death philosophy of Initiative 119, and it went against the oath physicians take to save lives (Archdiocese of Seattle, 2005).

As a physician, Dr. Walter D. Meester opposed Initiative 119. He told American Medical News, “In Judaeo-Christian ethics, killing by physicians has always been condemned. If one allows a small change in attitude-a lethal injection for pain-the next step may be involuntary action. This is what history has taught. Small changes in attitudes eventually led to killing people in Nazi Germany” (Case, 1991).

Jennifer Hanscom, Senior Director of The Washington Medical Association said that the organization did not approve support initiative 119 and more specifically, the practice of physician assisted suicide because it is the physician’s job to relieve suffering and prolong life. She stated, **“**As physicians we agree we need to play a critical role in easing pain and suffering of the dying. When there is no hope of being restored to health, we should assure patients that they aren’t going to suffer and will be kept comfortable. Physicians and other providers must come to terms with how we treat the dying and work to improve the care provided to loved ones as death approaches” (Hanscom, personal communication, 7-15-08). Hanscom also stated, **“**The benefit of having this initiative before the people is to start the discussion of end of life options and preparing for the end of life. As a result, the WSMA is actively working to improve care for patients at the end of life with our End of Life Consensus Coalition” (Hanscom, personal communication, 7-15-08).

In November 1991, the voters in the State of Washington defeated Initiative 119, the “Death with Dignity Act” 54% to 46%. No Exit Poll data was found for Washington to see how citizens voted according to religion, age, and gender.

After failing to legalize Initiative 119 in 1991, citizens tried to legalize physician assisted suicide three times through the legislature in 1995, 1998, and in 2006.

Booth Gardner was Governor during Washington's struggle to legalize physician assisted suicide through Initiative 119. Even though Initiative 119 was proposed during Governor Gardner's tenure, he was not involved in the physician assisted suicide battle. Gardner however, has waged a fierce campaign to have physician assisted suicide legalized in Washington and placed on the ballot for vote in 2008. In an interview with the New York Times Magazine in December, 2007, Gardner stated that he still wanted to be involved in public life even though he was no longer a Governor. He was asked why he wanted to push a new initiative to legalize assisted suicide. Garner said, "I want to be involved in public life. I was looking for an issue, and this one fell in my lap. One advantage I have in this thing is that people like me. The other is that my logic is impeccable. "My life, my death, my control" (Bergner, 2007). Gardner told The New York Times Magazine that implementing Initiative 1000 is a first step, which allows the expansion of the "right" to come later. Initiative 1000 would be patterned after Oregon's Death with Dignity Law. The initiative would allow terminally ill patients who have six months or less to live the right to ask for, receive and administer to themselves a medication that would end their lives while being under medical supervision (Compassion and Choices, 2008). Gardner suffers from Parkinson's disease and would not be able to end his life under I-1000 because his condition, though it may cause great pain and suffering, is not terminal.

California-California Death With Dignity Act Proposition 161 (1992)

California has the largest population of white Americans and Native Americans in the United States. It also has a large population of Hispanics and Latinos. California has a mixed political culture because the state is so large. Because of California's diverse racial composition, the state is heterogeneous. Heterogeneous states have large white and minority populations (Hero and Tolbert, 1996, p. 853). The dominant cultures in California are moralist-individualist and moralist-traditionalist (Elazar, 1984, pp. 124-125). In a moralist-individualist culture, citizens seek the good of society or a better social order, but come up against opposition from those who value individual freedom. In a moral-traditionalist culture citizens also focus on the good of society, but they come up against citizens who focus their efforts on continuity. Because there is such a mixture of cultures in California, public policy outcomes in the state are often nontraditional and revolutionary. For example, California was the second state to legalize abortion and one of the first states to legalize domestic partnerships for gay couples. Additionally, California was the first to disallow illegal immigrants social services and discontinue affirmative action. Both measures were approved by the voters of California. As a result of California's voter initiatives that call for constitutional amendments, California has a one of the largest constitutions on record (California Secretary of State, 2008).

Because the initiative process has been so effective in helping set California's agenda, it is called California's fourth branch of government. On October 10, 1911, California became the 10th state to adopt the initiative process, and the process is outlined as follows: the text of the proposed law must be drafted; after the law is written, supporters must present the idea for the law to the Legislative Counsel in which 25 or more electors must sign the request for a draft of the proposed law; the draft of the law must then be given to the Attorney General with a written request that a title and summary of the chief purpose and points of the proposed initiative measure be prepared; the Attorney General then prepares an official title and summary of the initiative; when the official title and summary is complete, the Attorney General must send it to the sponsors, the Senate and the Assembly, and the Secretary of State, and after receiving the title and summary, sponsors of the initiative are allowed up to 150 days to collect signatures. The necessary amount of signatures should be no less than five percent of the total votes cast for Governor at the last gubernatorial election. After the correct number of signatures has been collected, they are filed with the appropriate county elections officials (California Secretary of State, 2008).

California citizens have been leaders in creating legal change regarding domestic partnerships, illegal immigration, and affirmative action, but also physician assisted suicide. In a living will, the California Natural Death Act (1976) permitted patients or their family, when the patient is unconscious, to discontinue the use of any life sustaining treatment (Jacobs, 1992a). Additionally, in 1983, California enacted the Durable Power of Attorney for Health Care Act. This Act was significant because it allowed patients to choose a person or persons to make decisions and act on their behalf. In 1988, Americans Against Human Suffering were catalysts for trying to legalize physician assisted suicide by starting their campaign. Americans Against Human Suffering were not able to collect all of the necessary 372,000 signatures needed to qualify (Humphry and Clement, 1998, pp. 217-218). Attorneys, Robert Risley and Michael White coauthored the Humane and Dignified Act. The Act was drafted after Robert Risley's wife died of cancer in 1984. Efforts to get the act to the legislature were also unsuccessful. Risley and White then tried to amend the California Constitution to extend the right to privacy to include the right of terminally ill patients to physician aid in dying (Otlowski, 1997, p. 365). Americans Against Human Suffering was unsuccessful in all of their efforts to change physician assisted suicide legislation. According to Otlowski (1997), their failure can be attributed to a lack of funding, weak organization and inexperienced leadership.

In 1992, Americans Against Human Suffering became Californians Against Human Suffering. Under their new name, the group proposed physician assisted suicide legislation that did qualify to be placed on the California ballot. Californians Against Human Suffering sponsored the California Death With Dignity Act (Clark, 1997, p. 4). This initiative was a revised version of Washington's Initiative 119 and resembled the Natural Death Act. California's proposal was different in that it limited physicians' involvement in the assisted suicide process. It would have allowed a mentally competent adult to voluntarily execute a revocable directive governing the administration of aid in dying. "Aid-in-dying" referred to a procedure that would end the life of a terminally ill patient using a painless method and carried out by the physician or self-administered by the patient (Worsnop, 1995, p. 407). "Terminal" referred to an incurable condition that was diagnosed two physicians or more that would result in death within six months or less. The initiative would have protected physicians, nurses and hospitals that provide aid in dying ensuring that they receive immunity from criminal, civil, or administrative action (Worsnop, 1992, p. 162; Jacobs, 1992d).

Additionally, the initiative required mental competency, annual reporting and documentation to be filed with the state Department of Health Services (Walters, 1992).

Initially, according to a Field poll, The Death With Dignity Act had 68% support from voters. The measure was supported by family members of terminally ill patients, The Hemlock Society, The National Organization for Women of California, The Gray Panthers, The San Francisco and Beverly Hills Bar Association, The Southern California ACLU, the Unitarian Churches, and Dr. Warren Bostick, the former president of the California Medical Association (Humphry, 1993, 103; Jacobs, 1992d). Proposition 161 was also supported by the Los Angeles Gay and Lesbian Community Center and Being Alive, and AIDs organization (Jacobs, 1992d). Supporters spent \$40,000 in Los Angeles and \$15,000 in San Diego in radio trying to persuade voters to approve Proposition 161 (Hillyard and Dombrink, 2001, p. 61). In total, supporters spent \$1.7 million dollars on the campaign to legalize assisted suicide through Proposition 161.

Supporters for Proposition 161 utilized free ads and radio ads (Jacobs, 1992c). In one ad, a lawyer from Los Angeles, California discounted opponents of Proposition 161 ads. He stated, “The opponents, a powerful group of religious zealots, will spend millions, even to distort the truth” (Jacobs, 1992c). A part of the ad was a women claiming she was dying even though she had tried several forms of treatment, but none had been successful, and she did not want to continue to suffer. The radio ads were not as powerful because they were limited in the number of stations that aired them and limited in how often they were aired because of diminishing funds by supporters of Proposition 161.

Proposition 161 was opposed by many groups in the state, including religious organizations, medical and hospital groups and political organizations. The religious organizations included the Roman Catholic Church, the Knights of Columbus, the Catholic Bishops of California, the Byzantine Rite of Van Nuys, and various other religious organizations (Jacobs, 1992c). The medical organizations included the California Nurses Association, The California Association of Hospice and Health Systems, the California Medical Association, the American Cancer Society, the state's largest AIDS patient support agency (Jacobs, 1992c). Opposition also came from the National Right to Life, The California Pro-Life Council (Hillyard, 1998, p. 74), the California Republican Party and some of the state's newspapers (Humphry, 1993, p. 103). Those that opposed the initiative, coined "No on 1", spent $90,000 just in San Francisco alone (Hillyard and Dombrink, 2001, p. 61). In total, opponents spent $3.6 million dollars in a campaign to defeat Proposition 161 (Hillyard and Dombrink, 2001, p. 60).

As with Washington's opponents to Initiative 119, opponents of Proposition 161 focused their advertisements on the flaws of the measure, and the fact that the measure did not have genuine safeguards. One ad said, "If a diagnosis is wrong, someone you know may choose physician assisted suicide death by mistake. Death by mistake" (Smith, 1995, p. 34). One poignant ad depicts a character portraying Dr. Jack Kevorkian going into a patient's room to kill her by lethal injection. This ad was so powerful that it received awards (Smith, 1995, p. 34).

Many opposed the measure because they felt it was not drafted well. Opponents objected to the act because it included no requirements for a psychological evaluation, no requirement of family notification and no specified waiting period between the time the patient asks for assistance and their actual death (Olszewski, 1992). Another complaint by opponents was that the California Death Act when written did not clearly specify certain safeguards, mainly, because those protections were present in existing laws (Humphry, 1993, pp. 103-104). This observation was present in the proposition's "Declaration of Purpose". The Declaration notes how important it is for a patient to retain his or her self-determination, and it also noted how detrimental prolonging a patient's life could be. The Declaration stated that uneccesary suffering and loss of dignity could be caused by prolonging life. As a result of this Declaration of Purpose, many were misled to believe that there was no legislation in place that allowed patients to refuse life prolonging and sustaining treatment.

This initiative failed 46% to 54%. Even though the proposition was not approved, there were over 4, 500,000 who voted in favor of the measure. Exit Poll data taken in 1992 by CNN showed that 27% of population that voted was Protestant, 32 % were Catholics, and other Christians accounted for 15%, 11% was non-religious and the remainder of the population was identified as other. Sixty-one percent of Protestants voted No and 39 % voted Yes whereas fifty-six percent of Catholics and other Christians voted No and 44% voted Yes (CNN, 1992). There was no data on how citizens identified as other and non-religious voted. Citizens 18 to 59 accounted for 81% of the population and citizens 60 and over accounted for 19% of California's population that voted (CNN, 1992). Forty-eight percent of citizens 18 to 29 voted No and 52% voted Yes whereas fifty-four percent of citizens 30 to 44 voted No and 46% voted Yes (CNN, 1992). Fifty-six percent of citizens 45 to 59 voted No and 44% voted Yes (CNN, 1992). Males accounted for 51% of the population and had a split vote, fifty percent voted No and 50% voted Yes (CNN, 1992). Females accounted for 49% of the population, and 56% voted No and 44% voted Yes for Proposition 161 (CNN, 1992).

This shows how citizens vote according religion, age and gender, and it is important because it helps support the theory that physician assisted suicide policy is influenced by these three factors. Table 4-1 shows how citizens voted in California for Proposition 161.

Table 4-1

California	Yes	No
Protestant	39%	61%
Catholic	44%	56%
Other Christian	44%	56%
Male	50%	50%
Female	44%	56%
18-29	52%	48%
30-44	46%	54%
45-59	44%	56%
60 and over	43%	57%

Source: CNN All Politics Election 1998-1992 Exit Polls

After, Proposition 161 failed in 1992, citizens made five failed attempts to legalize physician assisted suicide through the legislature in 1995, 1999, 2005, 2006, and 2007.

During California’s struggle to legalize physician assisted suicide, Peter Barton Wilson was governor. Governor Wilson was not active in the physician assisted suicide movement in 1992.

Oregon-Oregon's Death With Dignity Law (1994)

In Oregon, whites account for majority of the population. Asians and Hispanics also account for a large percent of the population. Because of Oregon's racial composition, it is homogeneous. The dominant culture in Oregon is moralistic (Elazar, 1984, pp. 124-125). However, there are a few communities in Oregon that share a culture. As seen with Washington's culture, when a culture is moralistic, the government is viewed as a necessary and legitimate tool for ensuring the good of society. According to Clucas and Henkels (2005), politics in Oregon can be best described as schizophrenic (p. 1). Early in the state's history, citizens in Oregon have been able to use the initiative and referendum process to set public policy since 1902. Oregon has also enacted stronger land-use laws, created an innovative regional government, introduced voting through the mail, and legalized physician-assisted suicide (Clucas, Steel, and Henkels, 2005). Though Oregon has had many successes, there is still great political division in the state. Oregon is divided between progressives and conservatives. Progressive politics advocates for an active and strong government whereas conservative politics advocates a limited role for government. Conservatives also want a decrease in taxes, less restrictions on personal property, and protection for traditional social values (Clucas, Steel, and Henkels, 2005).

The diverging positions of progressives and conservatives were present in Oregon's struggle to legalize physician assisted suicide. In 1990, Oregon's chapter of the Hemlock Society introduced the "Death with Dignity Act" in the Oregon legislature, but it failed to go beyond the committee. In 1991during a legislative session, the "Death With Dignity Act" (SB1141) was introduced (Krois, 2001, p.90). However, the measure failed again. Senator Frank Roberts, a cancer patient, submitted a bill to legalize aid in dying in the

Oregon Legislature in 1987, 1989, and 1991. In 1994, the movement to legalize physician assisted suicide was successful in getting enough signatures for the inclusion of a measure to legalize physician assisted suicide on Oregon's ballot in 1994. The first step in the initiative process in Oregon is to draft the initiative. After drafting the initiative, the draft has to be certified by the Attorney General for signature collection. The Attorney General then has five days to write a ballot title for the initiative which is placed in the Voters' Pamphlet (Oregon's Initiative System, 2001). The next step of the process is signature collection. Petitioners must collect the signatures and then give them to the state Elections Division four months before the election so they can qualify for the ballot. It is the Elections Division job to verify that the correct amounts of signatures have been collected. After the signatures have been collected and the initiative has been approved for the ballot, campaigning begins. Through campaigning, sponsors of the initiative try to persuade voters to vote for the initiative (Oregon's Initiative System, 2001).

The 1994 Death with Dignity Act was also known as Measure 16. Oregon's Aid in Dying measure was sponsored by a group called Oregon Right to Die. The leaders of this group were medical professionals, a nurse named Barbara Combs, and Dr. Peter Goodwin (Krois, 2001, p. 91). Oregon Right to Die wrote Oregon's Death with Dignity law and ran the initiative campaign in 1994 to get the law passed. Measure 16 garnered the support of churches, political organizations, and medical organizations, the newspaper, and other organizations. The Unitarian Universalists, the United Methodists Church, and the Presbyterian Church supported the measure (Humphry and Clement, 1998, p. 233).

The Oregon Democratic Party supported the measure as well Senator Frank Roberts' wife, Barbara Roberts. In addition, political support was received from the National Organization for Women, the Oregon American Civil Liberties Union, and the Educators and Health Professionals. Even all the newspapers in Oregon endorsed Measure 16, except for the Portland Oregonian (Humphry and Clement, 1998, p. 232). Oregon Right to Die received over $600,000 in funding. A major portion of their funding came from the Hemlock Society (Krois, 2001, p. 96). They spent over $540, 000 on educating citizens on assisted suicide and advertising (Humphry and Clement, 1998, p. 223).

Compassion and Choices was originally the Hemlock Society. The Hemlock Society was formed in 1980 by Derek Humphry, author of the New York Times best seller *Final Exit*. Groups like Compassion and Choices and the Hemlock Society provided funding because they believed that in states that have voter initiatives, public education is the best way to reach and empower people to make informed decisions. Roland Halpern of Compassion and Choices stated that, "When the truth gets out there about what aid in dying laws are really about, and all of the unsubstantiated myths and rumors are exposed, the majority of people support the autonomy issue. And even though there are a fair number of people who would never use the option as a personal choice because of religious or moral convictions, they still believe that others should not be denied the choice just because they hold different beliefs or values" (Personal Communication, 4-24-08).

The United Church of Christ (UCC) also supported Measure 16, but in an interview with Barbara Baylor, the Minister for Health Care Justice for the Church, she stated, "I need to make it clear that we ARE NOT supporting Physician Assisted Suicide, but rather, Physician Aid in Dying. We support end-of-life choices which permit adults who are dying to request and receive from a physician a prescription to hasten death if the patient finds his or her suffering to be unbearable" (Personal Communication, 7-25-08). The Church is a mainstream Christian denomination that was established in 1957 with the union of two Protestant denominations: the Evangelical and Reformed Church and the Congregational Christian churches. Currently the UCC has over 5, 500 churches in over 39 conferences nationwide, and over a million members. Baylor stated that the Church has its own resolution for physician aid in dying which resembles the "Oregon Death with Dignity Act" entitled *The Legalization of Physician Aid in Dying*. Several resolutions have been passed by UCC that speak to the rights and responsibilities of Christians regarding human death and we (UCC) have recently passed another Resolution that addresses the issue of Physician Aid in Dying (Personal Communication, 7-25-08). Initially, the measure had 63% support of voters. A poll conducted by Roper found that certain words have a major impact on support for physician assisted suicide. For example, 55% of people supported the term "euthanasia" and 44% supported "physician assisted suicide and lethal injections (Humphry and Clement, 1998, p. 228). In response to these findings, Cheryl Smith who drafted the Death with Dignity Act changed the draft of the act numerous times. Smith was the legal advisor to the National Hemlock Society and an aide to Hemlock's co-founder, Derek Humphry. Oregon's Death with Dignity Act was not Smith's first time writing an assisted suicide proposal.

As a student at the University Of Iowa College Of Law, Smith assisted in writing a "Model Aid-in-Dying Act" (Brandt et al, 1989-90, p. 125). Eli Stutsman, a lawyer and founding member of the Death with Dignity National Center, also helped write Oregon's Death with Dignity Act. Drafters included the terms the public supported in the draft of the Death with Dignity Act. Roland Halpern can attest to the power of words. In an interview, Halpern stated, "Let me start by saying we do not use the term assisted suicide, as we do not feel it accurately describes the informed decision of a competent, terminally ill adult to end his or her life. Suicide is usually an irrational act brought on by depression, despondency or other underlying cause that can arguably be identified and treated, and allow the person to go on and lead a productive life. Our own clients point out that suicide is about choosing death over life, an option they no longer have available to them. Instead, since they are dying anyway, they want some control as to how their death will occur" (Halpern, personal communication, 4-24-08). Peg Sandeen, Executive Director of The Death with Dignity National Center agreed with Cheryl Smith and Roland Halpern. Sandeen said, "We (the Death with Dignity National Center) support Death with Dignity as a state level policy which establishes a medical standard of care for a terminally ill, mentally competent adult Oregonian to request and receive a prescription to hasten death. We do not support the use of the term "physician assisted suicide." It is a broad and vague term that opponents of death with dignity have used to elicit fear" (Sandeen, personal communication, 6-4-08).

Oregon’s Right to Die campaign focused on helping citizens understand that they have a right to have choices about ending their lives, not government, religious beliefs or other external influences. In one ad, several people discussed the right to choose by saying, “This is my body. I don’t need you. I don’t need government. I don’t need any church playing politics with my choices, with my life. If I’m terminally ill, I will decide how and when and in what way I will end my life” (Hillyard and Dombrink, 2001, p. 248). At the heart of Oregon’s campaign to legalize assisted suicide was a television ad that ran for sixty seconds. In the commercial, Patty A. Rosen, a former nurse and head of Bend, a chapter of the Hemlock Society, relayed her personal and very emotional experience of how she aided with her daughter’s death. Patty Rosen spoke of how she disregarded the law and obtained pills that would end her daughter’s life. Rosen says, “I am a criminal. 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. Jody had a few weeks to live when she decided she wanted to end her life. But it wasn’t legally possible. 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 for the first time in months” (O’keefe, 1994a) She then proceeded to appeal to viewers to approve of Measure 16 so that it would be legal for others to take such actions, if it were their choice. Even though this ad was very persuasive, it was also found to be untrue. Just two years prior during California’s battle to legalize assisted suicide, Rosen stated that the pills were not successful in ending her daughter’s life and she needed to use lethal injection to complete the task. Rosen said, “So she went to sleep. I didn’t know about plastic bags. I wish I had.

Because...It seemed to be back firing. And I was fortunate enough at the very last to be able to hit a vein right.... Before I could do that, the one son came into the room.... took his hands and held her veins for me.... I said, ‘Oh God, she’s startin’ to breathe again.’ And the other son said, ‘I'll take a pillow” (Marker, 2001, pp. 363-394).

Oregon Right to Die campaign had a twofold focus. Not only did it appeal to voters emotionally by letting them know they had a right to choose when making end of life decisions, but it also appealed to voters religiously. More specifically, some ads focused on sentiments against religion. Supporters used these antireligious sentiments because Oregon has a higher percentage of citizens not affiliated with a religion than many other states. Also, opponents of Measure 16 consisted of many religious groups who provided funding to oppose the measure, and supporters chose to play up the link between religion, opposition to funding and physician assisted suicide. One ad stated, “You know, there are just some people who believe they have a divine right to control other people’s lives, and they better back off because it’s none of their business” (O’Keefe, 1994b; Smith, 1995, p. 34).

Oregon Right to Die strategically planned its efforts to be successful. The major strategy used was to write a policy that included safeguards to protect vulnerable individuals. The measure attempted to bypass some of the problems associated with Washington and California’s initiatives. Oregon’s “Death with Dignity Act” resembled Washington and California’s initiatives in that it prohibited doctors from lethally injecting patients to terminate their life (Smith, 1995, p. 29). Sandeen stated, “We convened a wide array of concerned individuals including physicians, patients, family members, clergy, nurses, pharmacists, lawyers, legislators and more.

Everyone had a say in how the law was written. The major strategy we used was to write a good law, a great law that would work as intended" (Personal communication, 6-4-08).

Under Oregon's Death with Dignity Law, a person must be an Oregon resident, 18 years of age or older, must have decision making capacity, and must be suffering from a terminal disease that will lead to death within six months (Meisel et al, 2004). A patient must make one written and two oral requests for medication to end his or her life, the written one provided in the Act, signed, dated, witnessed by two persons in the presence of the patient who can attest that the patient is "capable, acting voluntarily, and not being coerced to sign the request", and there are strict qualifications as to who may act as a witness (Battin, Rhodes, Silvers, 1998, p. 444). The patient's decision must be an informed one, and the attending physician is thus obligated to provide the patient with information about the diagnosis, prognosis, potential risks, and probable consequences of taking the medication to be prescribed, and alternatives, "including but not limited to, comfort care, hospice care and pain control" (Battin, Rhodes, Silvers, 1998, pp. 444-445). Another physician must confirm the diagnosis, the patient's decision-making capacity, and if the patient's decision is voluntary. There are requirements for counseling if the patient is thought to be suffering from a mental disorder which may impair his or her judgment, for documentation in the patient's medical record, for a waiting period, for notification of the patient's next of kin, and for reporting to state authorities (Meisel et al, 2004).

The patient has the right to rescind the request for medication to end his or her life at any time. Having met the above requirements, the patient is entitled to a prescription for medication to end life.

The Coalition for Compassionate Care opposed Measure 16. The Coalition was comprised mostly of religious groups like the Mormons, the Evangelical Church, the Roman Catholic Church, the Assemblies of God, the Church of Nazarene, the United Methodist Church, the Muslims of Oregon, and the Episcopal Church (Smith, 1995, p. 34). The Coalition was also comprised of medical professionals, who later joined the group, such as the State Pharmacists Association, the Oregon Hospice Association, and Physician and Nurses Against Measure 16 (O'Keefe, 1994b). In total, the Coalition of Compassionate Care received over $1.5 million, and much of this funding was spent on advertising to oppose Measure 16 (Oregon Secretary of State). The Roman Catholic Church raised majority of the funding to oppose Measure 16.

Opponents of Measure 16 focused on educating voters on the dangers of Measure 16 and why they should not vote in favor of the measure.In one ad, a nurse talked about the lack of a counseling requirement for Measure 16. She said, "Many terminal ill patients become depressed. It's not uncommon for them to contemplate suicide. They fear whether they are going to have pain. They fear what the quality of life is going to be like. The worst part of Measure 16 is that there is no mental health counseling required. Many doctors fail to recognize depression in patients with terminal illness and a patient could make this decision for all the wrong reasons. Vote no on Measure 16. Oregon can live without it" (*Oregonian*, 1994).

Measure 16 was opposed for several reasons. One, it did not allow physicians to give the lethal injection to the patient, but does allow the patient or others to administer the injection. Two, the death certificate of the patient would state that they died of an overdose that was legally prescribed as opposed to saying they died of suicide.

Three, the family of the patient did not require that the family be notified. Four, the patient is supposed to be a resident of Oregon, but the measure did not clearly state what agency would determine Oregon residency. Lastly, the measure required that only a sample of physician assisted suicide cases be reported to the State.

Opponents felt that doctor patient relationships might be compromised, and doctors would become killers. They felt that people who were misdiagnosed may seek physician assisted suicide when they really are not terminally ill or that patients might choose physician assisted suicide because they have no money for adequate medical care (Hillyard, 1999, p. 115). Religious opponents felt that the neither government nor medical officials should approve of an act that is immoral.

Barbara Combs discounted the complaints of religious opponents. She felt that they were trying to put their ideas off on the citizens of Oregon (Steinfels, 1994). As a show of Combs' and other proponents' support for legalizing assisted suicide and not allowing the Roman Catholic Church to impose their ideas, a television ad ran asking, "Are we going to let one church make the rules for all of us"? According to the Ethical and Religious Directives for Catholic Health Care Services, an official used at the National Conference of Catholic Bishops in 1994: "The truth that life is a precious gift from God has profound implications for the question of stewardship over human life. We are not the owners of our lives, and hence do not have absolute power over life. We have a duty to preserve our life and to use it for the glory of God; but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. Suicide and euthanasia are never morally acceptable options" (National Catholic Bioethics Center, 2008).

Opponents of Measure 16 ran a much calmer campaign than opponents of Initiative 119 and Proposition 161. Washington and California's opponents made an emotional appeal to voters whereas Oregon's opponents made an intellectual appeal to voters about why they should not legalize physician assisted suicide. According to Smith (1995), opponents of Measure 16 did not go for the "emotional jugular vein" or "never got down and dirty" (p. 34).

In spite of the opposition, on November 8, 1994, by a 51%-49% vote, Oregon voters approved the "Oregon Death with Dignity Act" (See Appendix D). A surprising turn to Oregon legalizing assisted suicide was the fact that Medicaid in Oregon would help indigent citizens pay for assisted suicide (Postrel, 1994; Barnett, 1999). The measure made it legal for Oregon doctors to prescribe lethal drug overdoses to terminally-ill patients who asked to die (Hendin, 1997, p. 33). Doctors were granted full immunity from prosecution if they followed Measure 16's provisions (Worsnop, 1995, p. 408). Oregon became the first and only state in the U.S. to pass such a measure. Exit poll data taken in 1994 by CNN did not have a question about religion, but according to Adherents.com Oregon has a population of 82.8% that is affiliated with a religion and 17.2% that is not affiliated with a religion. According to CNN's poll, citizens 18 to 60 accounted for 77% of the population, and citizens 60 and over accounted for 23% of the population. Thirty-seven percent of citizens 18 to 29 voted No and 63% voted Yes whereas fifty-one percent of citizens 30 to 44 voted No and 49% voted Yes (CNN, 1994). Forty-three percent of citizens voted No and 57% voted Yes (CNN, 1994). Males accounted for 50 % of the population, and females accounted for 50% of the population that voted (CNN, 1994). Forty-two percent of males voted No and 58% voted Yes, whereas fifty-four percent of females voted No and 46% voted Yes (CNN, 1994). As it is in California, this exit poll data for Oregon is significant because it helps support the theory that physician assisted suicide policy is influenced by age and gender. Table 4-2 shows how citizens voted on Measure 16.

Table 4-2

Oregon	Yes	No
Male	58%	42%
Female	46%	54%
18-29	63%	37%
30-44	49%	51%
45-59	57%	43%
60 and over	44%	56%

Source: CNN All Politics Election 1998-1992 Exit Polls

A push to include lethal injection as a method for ending a person's life began shortly after Measure 16 passed. Derek Humphry was one of the main advocates for the inclusion. Even though Oregon legalized assisted suicide, he believed the law was flawed because it did not include lethal injection. His position was based on a study conducted in the Netherlands that showed that pills are not always successful at ending a person's life. Humphry argued because of the limited success of pills to end a person's life, lethal injection should be permitted.

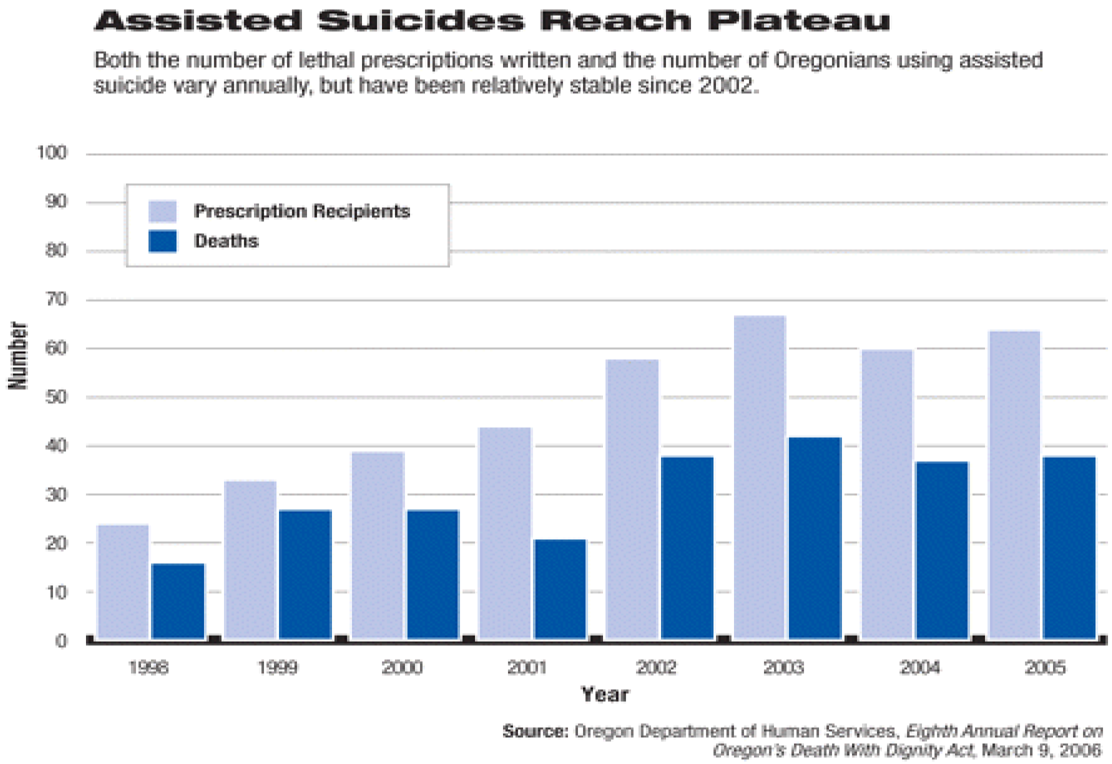
Humphry stated that, “The only two 100 percent ways of accelerated dying are the lethal injection of barbiturates and curare or donning a plastic bag after taking pills” (Humphry, 1994).

Also following the passage of Measure 16, those who opposed the measure challenged its constitutionality in court. In 1995, Measure 16 was declared unconstitutional in a federal district court in Oregon. An injunction was then placed on the measure. In 1996, the case was dismissed by an appeals court because those who opposed the law were not able to prove that they faced immediate harm if the measure was legalized (Daar, 1995, p. 805). The “Death with Dignity Act” went into effect on October 27, 1997 as a result of the U.S. Supreme Court refusing to hear the case on appeal. Due to serious flaws in the Oregon Death With Dignity Act the Oregon Legislature passed a bill to return Measure 16 to the voters for possible repeal in the November 4, 1997 election. The new initiative to repeal the previous measure was called Measure 51. Oregon Right to Die headed the campaign to stop the repeal. Oregon voters rejected Measure 51 by a margin of 60%-40% (Leone, 1997, p. 49).

Measure 16 was challenged again in 2001 by Attorney General John Ashcroft. On November 6, 2001, he issued a mandate that gave federal drug agents the authority to identify and punish doctors who prescribed drugs to patients to commit suicide. Ashcroft argued that assisting in a suicide is not a “legitimate medical purpose” under federal law (Eggen and Connolly, 2001). Many felt Ashcroft overstepped his boundaries and the government was trying to void a law that had already been challenged and voted on twice by citizens in favor of legalizing assisted suicide. In 2002, Oregon went to court to overturn Ashcroft’s decision and won (Oregon v. Ashcroft, 2002).

By the end of 2004, 208 individuals have ended their lives with the help of lethal prescriptions. Assisted suicide varies annually, but overall the number of patients has been stable since 2002. See Table 4-3.

Table 4-3



Assisted Suicides Reach Plateau

Both the number of lethal prescriptions written and the number of Oregonians using assisted suicide vary annually, but have been relatively stable since 2002.

Source: Oregon Department of Human Services, *Eighth Annual Report on Oregon's Death With Dignity Act*, March 9, 2006

Source: Oregon Department of Human Services, Eighth Annual Report on Oregon's Death With Dignity Act

After Oregon Right to Die succeeded in getting physician assisted suicide passed in Oregon, the founders of the organization reorganized and established a 501(c) (3) non-profit organization, the Oregon Death with Dignity Legal Defense and Education Center. This organization merged with the Death with Dignity National Center (a California corporation established in the 1990s in 2004. Leaders of this organization include Timothy Quill, a physician who is widely known for his expertise in hospice care and end-of-life issues. Betty Rollin, a retired journalist, is a member of the board of directors. She wrote the New York Times best seller *Last Wish*, about her mother's desire for a peaceful and dignified death. Other board members who have contributed to the death with dignity movement include: Alan Meisel, Mike White, Carol Pratt and Buzzy Baron (attorneys with expertise on this issue); Doc Mayo (philosopher); Connie Holden (nurse); Steve Telfer (lobbyist); and Ed Lowenstein and Sidney Wanzer (physicians) (Peg Sandeen, personal communication, 6-4-08).

During Oregon's struggle to legalize assisted, Barbara Roberts was governor. Barbara K. Governor Roberts was the first and, to date, only woman to be elected as governor in Oregon. Roberts was a democrat and served only one term as governor, from 1991-1995 (Oregon Secretary of State). There were several factors that were probably responsible for Roberts' decision to not run for office again, but one of the main factors was the death of her husband from prostate cancer on October 31, 1993 (Oregon Historical Society, 2007). It was Roberts' late husband, Frank Roberts, the state senator, who three times had introduced Oregon's "Death With Dignity" law. Barbara Roberts wrote a book that detailed her experiences with her dying husband. She supports physician assisted suicide; however, she does not suggest that physician assisted suicide can or should be used heavily, instead death and dying should be a welcomed topic of discussion. "We are surrounded by a culture afraid to use the words *dead, death, died, or dying*" (Roberts, 2002, p. 4). She said that patients are kept hooked up to heart monitors, blood pressure systems, intravenous feeding devices, catheter tubes and respirators. "What a dying person needs is comfort, closeness, dignity, and in some cases, pain control" (Roberts, 2002, p. 5). Roberts feels that physician assisted suicide and legalizing the Oregon "Death with Dignity" law has been a positive experience for Oregon. She stated, "In Oregon our experience with the law has caused citizens' attitudes to grow more supportive with each year of the law's use. Perhaps most importantly, Oregon's law has brought the dying process out of the closet for patients, physicians, politicians, and families" (Roberts, 2002, p.105).

Michigan-Proposal B (1998)

In Michigan, whites account for the largest percent of the population and blacks account for the next largest percent. Because of the state's racial composition, it is homogeneous. The state culture in Michigan is mixed as it is in California and Oregon. The two dominant cultures in Michigan are moralist and moralist-individualist (Elazar, 1984, pp. 124-125). There is also an individualist-moralist and a moralist-traditionalist culture in Michigan (Elazar, 1984, pp. 124-125). Though a Republican state for many years, Michigan has become a bipartisan state politically divided. Division has been between races, labor versus capital, and even Lower versus Upper Peninsula (Browne and VerBurg, 1995). This division has changed how citizens and the government engage in politics. Lobbyists and political action committees are more prevalent and there is a stronger and more experienced governorship, bureaucracy, and legislature that have produced an activist, policy-directed state government (Browne and VerBurg, 1995).

Physician assisted suicide is one issue that Michigan's citizens and government have tried to address. Some felt that the best way to legalize assisted suicide was to place the measure on a ballot for vote. The Michigan Constitution allows citizens to have initiatives and referendums. Once a citizen writes an initiative it is their job to submit it to the Secretary of State for approval. The Board of State Canvassers is available to help applicants create the correct form for the proposed initiative. After the application is submitted to the Secretary of State, the Board of State Canvassers must certify that the correct amounts of signatures have been collected. Signatures must be equal to or greater than 8% of the votes cast in the last election for Governor in Michigan (Bowerman, 2006).

Then the State Director of Elections writes the ballot question and summary based on the draft of the initiative. Once the Board of Canvassers reviews and makes any necessary changes to the summary, the initiative is ready for voting (Bowerman, 2006).

On June 4, 1990, Dr. Jack Kevorkian, a pathologist from Michigan assisted a patient in committing suicide. The patient was Janet Adkins, a 54 year old woman who was diagnosed with Alzheimer's disease. She died with the assistance of Jack Kevorkian's "suicide machine". This machine allowed patients to commit suicide by giving themselves a lethal dosage of intravenous drugs. The Michigan state legislature tried to pass a law that would criminalize physician assisted suicide in response to Adkins' suicide (Krois, 2001, p. 103). Senate Bill 32 was presented to the House Committee Judiciary. The bill would have made physician assisted suicide a felony punishable by a maximum prison term of four years and a fine of $2,000 (Krois, 2001, p. 103). The bill did state that the withholding of medical treatment, procedures or medicine that may hasten the patient's death was not considered as suicide. After another bill was introduced to legalize aid in dying, The Michigan Commission on Death and Dying was established to study the issue of suicide (The Michigan Commission on Death and Dying, 1994). Their main goal was to determine if assisted suicide should be legal or not. In June 1994, the Michigan Commission on Death and Dying issued a report that stated that the legislature should decriminalize assisted suicide in Michigan and regulate physician assisted suicide and voluntary euthanasia, and if physician assisted suicide is legalized, safeguards should be implemented (Michigan Commission on Death and Dying, 1994). In 1994, the Senate passed another bill which banned physician assisted suicide (Krois, 2001, p. 105).

In the same year, Dr. Jack Kevorkian started a petition drive to place the issue of euthanasia on the November 1994 ballot. Kevorkian's petition offered an amendment to the state constitution which read: "The right of competent adults, who are incapacitated by incurable medical conditions, to voluntarily request and receive medical assistance with respect to whether or not their lives continue, shall not be restrained or abridged"(Nicol and Wylie, 2006, p. 196). Despite the continuous media coverage Kevorkian received while touring the state for the campaign, the effort came up short by tens of thousands of signatures. In December of 1994, the Michigan House of Representative voted to make the continuation of a proposed statute banning assisted suicide contingent on a statewide referendum vote. This provision to have the public accept or reject the ban became the point of contention causing the bill to not be given formal approval.

Between 1994 and 1998, prosecutors in Michigan tried to convict Kevorkian of violating the common law ban on physician assisted suicide, but were unsuccessful. Instead of physician assisted suicide charges, he was convicted on murder charges in 1999. During the time of June 1990 and January 1996, at least 27 peoples' lives were ended because of Jack Kevorkian's death machines (International Task Force on Euthanasia and Assisted Suicide, 2008). Table 4-4 details the names and dates those killed by Kevorkian.

Table 4-4

Janet Adkins, 54, 6/4/90	Stanely Ball, 82, 2/4/93	Donald O'Keefe, 73, 9/9/93
Marjorie Wantz, 58, 10/23/91	Mary Biernat, 73, 2/4/93	Merian Frederick, 72, 10/22/93
Sherry Miller, 43, 10/23/91	Elaine Goldbaum, 47, 2/8/93	Ali Khalili, 61, 11/22/93
Susan Williams, 52, 5/15/92	Hugh Gale, 70, 2/15/93	Margaret Garrish, 72, 11/26/94
Lois Hawes, 52, 9/26/92	Jonathon Grenz, 44, 2/18/93	John Evans, 78, 5/8/95
Catherine Andreyev, 46, 11/23/92	Martha Ruwart, 41, 2/18/93	Nicholas Loving, 27, 5/12/95
Marcella Lawrence, 67, 12/15/92	Ronald Mansur, 54, 5/16/93	Erika Garcellano, 60, 6/26/95
Marguerite Tate, 70, 12/15/92	Thomas Hyde, 30, 8/4/93	Esther Cohan, 46, 8/21/95
Jack Miller, 53, 1/20/93	Patricia Cashman, 58, 11/08/95	Linda Henslee, 48, 01/29/96

Source: International Task Force on Euthanasia and Assisted Suicide, 2008

Over twenty five pieces of legislation were introduced to criminalize physician assisted suicide in an effort to stop Kevorkian from assisting other patients (Michigan in Brief, 1998). In 1998, a bill proposed by Senator William VanRegenmorter and approved by the Governor that made the assistance of suicide a felony was enacted by the Michigan legislature (Krois, 2001, p. 105). Under the law, if a person assisted someone in suicide, he/she could receive five years in prison and a fine of $10,000. Although the bill was effective in September 1998, it could not be enforced until the November election.

Early in 1997, a group called Merian's Friends formed with the intention of placing the issue of physician-assisted suicide on the ballot in hopes of legalizing the practice. Before trying to pass Measure B, through an initiative, citizens tried to legalize physician assisted suicide four times through the legislature in 1994, 1995, 1997, and 1998. Merian's Friends was formed in memory of Merian Frederick, a 72 year women who contracted Lou Gehrig's disease in 1989 and four years later contacted Dr. Kevorkian to seek his assistance with dying. Kevorkian was not convicted of killing Merian Frederick at his trial in 1996. She was Jack Kevorkian's 19th assisted suicide. The group developed a petition, with language nearly identical to S.B. 653, the legislation to legalize physician assisted suicide that was defeated in the Michigan Senate. Merian's Friends measure was supported by Democratic Gubernatorial candidate and Kevorkian's lawyer Geoffrey Fieger, Wayne County Prosecutor John Hair, Ex-Governor William G. Milliken and wife, Helen Milliken, retired auto workers Doug Fraser, and Irving Bluestone (Cain, 1998). Merian's Friends did not have the support of medical or a lot of political groups. Although Merian's Friends was formed in memory of a patient Kevorkian helped commit suicide, the group wanted to distance themselves from him. Basically, they wanted to end Kevorkian's unregulated activities and to separate their proposal from past failed legislation trying to legalize assisted suicide in Michigan.

On July 17, 1997, Merian's Friends started their campaign, gathering signatures at the Ann Arbor Art Fair. By October 1997, Merian's Friends was having such a difficult time gathering signatures that they announced that they would begin paying circulators $1.00 for every signature brought in.

Merian’s Friends hired National Voter Outreach, to collect signatures for them after trying unsuccessfully to collect signatures themselves (Right to Life Michigan, 1998). Merian’s Friends not only had trouble collecting signatures, but also money was limited. They sent out email messages asking for donations in the form of loans.

On May 26th, Merian’s Friends submitted their signatures. The Secretary of State’s office counted approximately 365,000 signatures that would be validly used to make sure that the signatures were legitimate. After Merian’s Friends submitted their signature, Citizens for Compassionate Care filed a case against them due to possible fraudulent behavior on behalf of Merian’s Friends. On July 20, 1998, the State Board of Canvassers refused to review all of the evidence Citizens for Compassionate Care submitted to challenge the Merian’s Friends petitions (*Detroit Free Press*, 1998). After the Board refused to review evidence, they named Merian’s Friends proposal Measure B (See Appendix G). The State Bureau of Elections drafted Proposal B (Christoff, 1998). Merian’s Friends were particular about terms used in the final draft of the proposal. They did not want terms such as “suicide” and “lethal doses of medication” used because the terms for many have a negative connotation and could be damaging to the group’s effort to legalized assisted suicide.

Initially, the initiative had 54% of support from voters (McGraw and Bell, 1998). Support for physician assisted suicide in 1998 is consistent with data found for support of the practice in 1996. In a study conducted by Bachman et al (1996), they found that support in the U.S. for physician assisted suicide is increasing; Michigan citizens are a part of this growing trend (pp. 306-308). Michigan citizens were asked which did they prefer most, a ban on assisted suicide or the legalization of assisted suicide.

Two thirds of Michigan adults favored the legalization of physician-assisted suicide, and about one quarter preferred a ban on the practice (Bachman et al, 1996, pp. 306-308). Surprisingly, many physicians were more opposed to a ban than legalizing physician assisted suicide if a complete ban or legalization were the only two options available. Specifically, physicians in the state desired that governmental and legal institutions not have a say or any authority in deciding whether or not the practice of physician assisted suicide should be legal. This is the position of the Michigan State Medical Society, which opposes any legislation regarding physician assisted suicide, one way or the other (Bachman et al, 1996, pp. 306-308). A strong value system and personal experiences impacts how a person feels about physician assisted suicide. For example, as has been seen in many studies and supported in this study, strongly religious people are most likely to not support legalizing physician assisted suicide than those who are not religious. Those adults and physicians in Michigan who said religion was a major part of their life opposed the practice the most (Bachman et al, 1996, pp. 306-308).

Ed Pierce, head of the assisted suicide advocacy group Merian's Friends, said Merian's Friends raised about $1 million, most of which it spent getting Proposal B on the ballot. The group hired a firm to collect signatures for the ballot which cost them about $750,000. The group planned to spend about $75,000 airing ads in Detroit, Lansing, Grand Rapids, Flint, Saginaw and Traverse City. Merian's Friends ran one ad for three days in these cities using former Governor William Milliken as a spokesperson (Durbin, 1998). They focused their campaign on making voters understand that they have a right to physician assisted suicide.

In the 30 second ad Milliken stated, “I believe citizens should be allowed to make end-of-life decisions according to their own religious and moral beliefs, not those of others or the state” (Durbin, 1998). Pierce said the ad was probably his group’s only attempt to counter anti-Proposal B ads that had been running statewide.

The proposal would allow physicians to prescribe lethal doses of medication to terminally ill adult patients who wanted to end their life. However, there were specified circumstances in which a Michigan resident, or a relative from another state could get a prescription to end their life. First, two physicians would have to determine the patient has terminal illness with less than six months to live. Second, a psychiatrist would have to determine that the patient is mentally competent and making a voluntary request. Third, the patient must wait seven days before the physician can prescribe the lethal dose. Fourth, the patient must be informed about other treatments, such as pain control and hospice care. Finally, the proposal would create a gubernatorially appointed and publicly funded state oversight committee (Heinlein, 1998).

Citizens for Compassionate Care, a committee to defeat Proposal B, started its campaign with a press conference at the state capitol on September 14, 1998. Compassionate Care was comprised of political figures such as Lt. Gov. Connie Binsfeld doctors, groups such as Right to Life of Michigan, Michigan State Medical Society, Michigan Hospice Organization, Michigan Catholic Conference, Michigan Republican Party, and Michigan Disability Rights Coalition (Cain, 1998). Citizens for Compassionate Care raised around $5 million to defeat Proposal B, according to campaign finance statements. Opponents of Proposal B focused their campaign on the dangers of the measure.

Most significant for the campaign were a combination of television ads produced by a Grand Rapids ad firm, Hanon McKendry. In an ad entitled the “Slide Show”, several picture slides of teens, Jack Kevorkian, and terminally ill patients are shown, and then the ad states, “Though it has been fairly short lived, the history of assisted suicide has been profound. In the Netherlands, assisted suicide has led to people being killed involuntarily. In Oregon, since the legalization of assisted suicide, the teen suicide rate has dramatically risen over 16 percent. And, in Michigan, well, we all know what happened here. B is bad legislation. Vote “no” on B” (O’Keefe, 1994a). In an ad that represented the theme the “Death State”, the camera scans a small cemetery outside St. Patrick’s Church in Vergennes Township giving an aerial view of headstones as a voice warns that Michigan could become the answer to the question: “Where do we go when we die?” (Roelofs, 1998). Some of the ads were highly criticized and stopped running because of the negative or unappealing context they presented Proposal B in or because of false information presented in the ads. For example, “Slide Show I” spoke of the dramatic rise in the teen suicide rate to over 16 percent, however, those statistics were inaccurate (*The Detroit News*, 1998b). Opponents of Proposal B also focused on educating citizens about alternatives other than assisted suicide for the terminally ill. Gary Pokorny, president of the firm that produced television ads for Compassionate Care against Proposal B, said the new ads would run in all state television markets at a cost of $200,000. “We should be thinking about killing the pain, not the patient,” Pokorny said (Euthanasia, 2008). Citizens for Compassionate Care provided funding and Michigan’s government helped increase education to citizens about options for the terminally ill. Jim Haveman, director of the Michigan Department of Community Health, said the state planned to spend $150,000 in 1999 to train medical professionals in end-of-life care and help promote over 100 hospice care programs in Michigan (Euthanasia, 2008). A part of the government's educational program is Michigan's Circle of Life program. The goal of the program is to lower suicide occurrences for the terminally ill by providing helpful information about legislation such as Michigan's Dignified Death Act, power of attorney, and other alternatives (Euthanasia, 2008).

As Compassionate Care shifted their focus to educating citizens, their new theme became physician assisted living, said Kevin Kelly, managing director of the Michigan State Medical Society. The physician assisted living theme brought to life in 60 second ads information on alternatives for the terminally ill. The idea for the ad was taken from 'Tuesdays with Morrie'. Mitch Albom wrote the book about end of life issues. Kelly believed that the book provided a positive depiction of physician assisted living. She stated, "Tuesdays with Morrie,' gives the point of view that physician assisted living can be wonderful," (Euthanasia, 2008).

In an interview with David Fox, Director of Public Relations and Federation Planning for the Michigan State Medical Society said their main focus for defeating the measure was through educating physicians. Fox said, "MSMS opposed the specific ballot proposal, the organization spent thousands of hours debating policy, educating physicians about improved end-of-life care and particularly pain management" (Personal Communication, 8-20-08). Even though opponents were victorious and defeated Proposal B, the Michigan State Medical Society is still dedicated to educating physicians.

Fox said, “Several years ago we developed a 40-page “Michigan Physicians Guide to End of Life Care” that we are in the process of updating right now and will redistribute to physicians across Michigan” (Personal Communication, 8-20-08).

After a massive public information campaign exposing the dangers lurking in the proposal, public opinion shifted. One week away from the election, the polls showed support for the measure had decreased. Compassionate Care wanted to defeat the initiative to legalize suicide because they felt it “was too long, too complex, too bureaucratic, and it threatened individual freedoms” (McDiarmid, 1998). Barbara Listing, President of Right to Life of Michigan, stated, “This initiative will only succeed through misrepresentation, and they will ignore our legislation to revolutionize pain management, they will ignore the hope for curing cancer and they will try to brainwash us into believing that killing is a new form of healing” (Right to Life Michigan News, 1998). Citizens for Compassionate Care also wanted the initiative defeated because they felt that the proposal would establish assisted suicide clinics, depressed people would be allowed to commit assisted suicide, doctors would have to go through training that teaches them how to assist someone commit suicide, residents who did not live in Michigan would be permitted to commit suicide, death certificates would be falsified, family did not have to be notified, and patients did not have to be competent when they took the lethal drugs to terminate their live.

The proposal was soundly defeated by 71% to 29%. Instead of legalizing physician assisted suicide, Michigan citizens wanted the State of Michigan to focus on effective alternatives, such as pain management and palliative care. The coalition fought so hard to defeat Proposal B because they felt that citizens would not consider assisted suicide as an option if information was readily available outlining other options and alternatives. Exit polls conducted in 1998 by CNN.com had no question for religion. However, according to Beliefnet.com, 85% of Michigan's population is affiliated with a religion and 15% of the population is not affiliated with a religion. Also according to the CNN's 1998 Exit poll, seventy-one of citizens 18 to 64 voted No and 29% voted Yes whereas 65% of citizens 65 and over voted No and 35% voted Yes to the measure. CNN's 1998 poll also found that 67% of men voted No and 33% voted Yes whereas women voted 74% No and 26% Yes for Proposal B. As with the data in California and Oregon, this data is significant because it helps support the theory that age, and gender influence the policy process and specifically, physician assisted suicide policy. Table 4-5 shows how citizens voted on Proposition.

Table 4-5

Michigan	Yes	No
Male	33%	67%
Female	26%	74%
18-29	29%	71%
30-44	28%	72%
45-49	31%	69%
60 and over	30%	70%

Source: CNN All Politics Election 1998-1992 Exit Polls

Faye Girsh, the Executive Director of The Hemlock Society stated: "The Catholic Church and Right to Life groups spent $5 million to pick apart a carefully crafted initiative. As a result, a small number of suffering people will not be able to get help from a compassionate physician to hasten the dying process" (Christian Life Resources, 1998).

She felt that it was inhumane to produce television ads that frightened and mislead citizens about death. Girsh believed that instead of spending money fighting Proposal B, money should have been spent on hospice care, health insurance, or on programs that prevented suicide. "If the Catholic Church and the Religious Right want to limit their members' choices for divorce, contraception, abortion, and help in dying, that is their right. But they should not be free to inflict these restrictions on others through the use of an outrageously unbalanced political campaign" (Christian Life Resources, 1998).

During Michigan's struggle to legalize physician assisted, John Mathias Engler was governor. He served as governor from 1991-2003 and was a republican governor. Governor Engler did not support physician assisted suicide. He signed Senate Bill 200 (SB 200), making assisted suicide a felony. "Starting September 1, 1998, Michigan will have in place legislation to stop individuals from assisting others in committing suicide," said Governor Engler. "It gives prosecutors the tools they need to convict those who assist someone in ending their life. And it will put out of business those who prey on the vulnerable" (The Pro-Life Infonet). SB 200 was sponsored by State Senator William Van Regenmorter (R- Hudsonville). Senator William Van Regenmorter called it "the most dangerous proposal to be on the Michigan ballot ever" (*Detroit News*, 1998). The bill amended the Penal Code to create a felony for assisted suicide. It provides for imprisonment of not more than five years, or a fine or not more than $10,000 or both for persons who know that an individual intends to kill him or herself and provides the means to kill or attempt to kill him or herself, participates in an act by which the person kills or attempts to kill him or herself, or helps the individual plan an attempt or actually take his or her life (The Pro-Life Infonet).

Maine-Death with Dignity-"Question 1" (2000)

Ethnic and racial minorities in Maine make up less than two percent of its population (U.S. Census Bureau, 2000).Whites account for the largest percent of the population and American Indian or Alaska native account for the second largest percent in Maine. Because of Maine's racial composition, it is homogeneous. Maine has a predominantly moralistic culture. Politics for citizens and politicians in Maine is a joint effort where politicians and citizens work together for the common good of society (Price, 2005, p. 5). With the common good of society in mind, government finds it necessary to intervene occasionally into private affairs. Maine is referred to most often as a state where citizens care for each other, but because parts of the state are individualistic in nature, citizens use politics as a method to maintain the status quo in areas such as the market and in family and personal issues (Price, 2005, p. 5). For example, citizens in Maine have fought for government to stay out of their affairs when dealing with the right to die with dignity.

In 1908, Maine adopted a constitutional provision that gave Maine's citizens power in the form of the initiative and referendum, which reinforces citizens' participatory political role in law making. In 2000, citizens tried to legalize physician assisted suicide by an initiative. Before trying to pass "Question 1" in 2000, citizens tried to legalize physician assisted suicide through the legislature in 1995, 1996, and 1997, but without success. Any Maine registered voter may circulate a citizen initiative. According to Maine's Secretary of State, the first step to the initiative is submitting a written application along with the full text of the proposed law to the Maine Secretary of State which includes the names, addresses and signatures of five Maine registered voters. After receiving the application, the Secretary of State must review the application, accept or reject it, and then provide a revised draft of the initiative legislation to the applicant. The applicant and Secretary of state must agree on final changes of legislation. After consenting on the final draft, the Secretary of State must provide the ballot question to the applicant within 10 business days. The Elections Division then provides an approved petition form to be circulated by the petitioners. The petition may be circulated for 18 months from the date of issuance, and the amount of signatures collected must be a least 10% of the signatures cast for Governor for a statute (Maine Secretary of State, 2008). The measure is sent to the Legislature if enough signatures have been collected. However, if the measure is not approved by the Legislature, it is placed on the ballot for a vote in the next statewide election (Maine Secretary of State, 2008).

Initially, it seemed as if the "Maine Death with Dignity Act," would pass because the proposal was very similar to the law that passed in Oregon and many of Maine's demographics were similar to the demographics in Oregon. The "Maine Death with Dignity Act," was placed on the ballot as "Question 1." Polls conducted via telephone in May, August, and September prior to the election showed 62-71% of citizens supported assisted suicide (Vollmar, 2000, pp. 1-2). "Question 1" asked, "Should a terminally ill adult, who is of sound mind, be allowed to ask for and receive a doctor's help to die" **(**The Maine Death with Dignity Act, 2000)?

As the campaign to legalize physician assisted suicide progressed, supporters from Oregon brought their support to Maine. Supporters such as Dr. Katrina Hedberg (Oregon's chief epidemiologist who co-authors Oregon's official assisted suicide reports), Ann Jackson (executive director of the Oregon Hospice Association), Barbara Coombs Lee (a chief author of the Oregon law and executive director of the assisted suicide advocacy group Compassion in Dying), and former Oregon governor Barbara Roberts gave Maine support by informing them about the positives of legalizing assisted suicide in Oregon. The editor of the New England Journal of Medicine also gave her support for Question 1" (Goad, 2000). Angell was very influential because of her position as editor, and her support for the Death with Dignity Act was significant because it opposed opinions of the American Medical Association. The Association does not support physician assisted suicide. Angell supported the Death with Dignity law because she felt it was compassionate and it honored patients' right to self-determination (Goad, 2000). A majority of the funds used by Death with Dignity came from the National Hemlock Association, Oregon Right to Die, and other proponents of assisted suicide (Vollmar, 2000, p. 2). Death with Dignity spent around $2 million trying to get voters to approve their proposal to legalize assisted suicide (Vollmar, 2000, p. 2).

Maine Citizens Against the Dangers of Physician-Assisted Suicide also campaigned simultaneously with Death with Dignity, but their goal was to counter legalizing assisted suicide. Those who opposed legalizing physician assisted suicide coined their fight, the "No on 1" which caused those who fought to legalize assisted suicide to name their campaign the "Yes on 1" campaign. The Maine Medical Association, a voluntary membership organization of physicians established in 1853, helped lead the fight against the assisted suicide initiative along with pro-life and religious organizations (Smith, personal communication, 7-12-08). More opposition for assisted suicide came from Maine Citizens Against the Dangers of Physician-Assisted Suicide which included groups such as Maine Medical Association, Maine Osteopathic Association, Maine Home Care Alliance, Alpha One, Maine Hospice Council, and the Roman Catholic Diocese of

Maine, National Right to Life, Maine Chapter of the American College of Physicians, and the National Legal Center for the Medically Dependent and Disabled. Help also came from the National Right to Life, in addition to help from the National Legal Center for the Medically Dependent and Disabled. These groups gave their assistance by conducting extensive research on assisted suicide and then mailing information that highlighted the perils of the proposed legislation to the homes of Maine's citizens (ProlifeInfo.org, 2000). Opponents ran television ads that countered the claims of supporters from Oregon, those who spoke about the positives of Oregon's law without realistically and truthfully addressing the negatives of the law. Opponents spent almost $2 million dollars trying to defeat "Question 1" (Vollmar, 2000, p. 2). The Catholic Diocese contributed $275, 000 to the campaign (Vollmar, 2000, p. 2). As Washington, California, Oregon, and Michigan's opponents did, opponents of "Question 1" focused their campaigns on educating citizens about the flaws and dangers of assisted suicide. Ads aired that used a Maine physician, a hospice director, and other citizens of Maine who were disabled as spokesmen. Each warned of the dangers and flaws of "Question 1". One ad used Oregon as an example of why assisted suicide should not be legalized in Maine. Countless pills shown as a voice stated that it would take 60 to 100 to end a person's life. The voice also told how a person could receive a lethal dose of medication in the mail, then Thomas Reardon, an Oregon doctor detailed some of the flaws that Oregon faced with assisted suicide.

He spoke of a situation in which a family member called 911 emergency operators because a prescription given to one of their family members to commit suicide caused major complications. He ended the ad by saying, “And I don’t want Maine to make the same mistake we did” (International Task Force on Euthanasia and Assisted Suicide, 2008).

Opposition ads were very telling and persuasive. They were so persuasive that proponents for legalizing assisted suicide fought to have the opposing ads removed from the air. However, sponsors of these ads showed television stations written documents that supported the claims in their ads (National Right to Life News, 2000). As a result, the ads continued to run. Because they were not successful at having the ads removed from the air, supporters of assisted suicide tried a different strategy. Supporters sought the help of John Kitzhaber, Oregon’s then Governor to do as former governor Barbara Roberts did, and speak about the pros of Oregon’s law. Governor Kitzhaber said, “Here’s the truth.”, “It’s working well” (International Taskforce and Assisted Suicide, 2008). He refuted the ad “No on 1” aired by Dr. Reardon, stating that a family called 911 about complications. Kitzhaber’s credibility was compromised when the “No on 1” campaign provided appropriate documents that showed the case of the 911 call being involved in a couple of articles in Oregon’s newspaper, the *Oregonian* (International Taskforce and Assisted Suicide, 2008). In one instance, Joe Hayes had to help his brother-in-law end his life. Patrick Matheny, his brother-in-law got a lethal prescription to end his life from Oregon Health Sciences University and experienced complications trying to take the medication. Hayes stated, “It doesn’t go smoothly for everyone. For Pat it was a huge problem. It would have not worked without help” (Hoover, 1999b).

Kandyce Powel, a spokesperson for the Maine Hospice Council, said, “Out-of-state agendas and perspectives are driving this issue in Maine” (International Taskforce, 2000). Also, Douglas Hodgkin, a political science professor at Lewiston’s Bates College, agreed. “We’re getting a national battle fought out in the state of Maine,” he said, and Mainers “should be aware of the possibility that somebody could be hijacking the process from the outside” (International Taskforce, 2000).

Gordon Smith, Executive Vice President for Maine Medical Association said, “The Maine Medical Association opposed the measure because the intentional causing of death was and continues to be a violation of medical ethics as interpreted by the Council on Ethics and Judicial Affairs (CEJA) of the AMA” (Personal Communication, 7-12-08). Many citizens opposed “Question 1” because they felt that there could be abuse of the law and that it misinterprets how one should die. This abuse could occur, if those in managed care push for patients to end their lives so as not to have to pay exorbitant hospice and medical bills. Dr. Mark Siegler, director of the Maclean Center for Clinical Medical Ethics at the University of Chicago did not support assisted suicide because he felt the law was dangerous. Siegler believed the law was dangerous because disenfranchised groups such as the disabled, elderly, and uninsured could be discriminated against because many of them do not have the resources to obtain health care (Goad, 2000). Opponents also felt that legislators did not make strong enough provisions to stop potential abuse. Patients do not have to give a notice to family members before ending their life and there is no way to make patients accountable for getting a referral from a mental health professional even though it is a requirement before a person is able to end their life (*The Portland Phoenix*, 2000).

Maine Citizens Against the Dangers of Physician Assisted Suicide fought a battle for close to a year to stop the legalization of physician assisted suicide by informing citizens of Maine about the dangers of assisted suicide. Brian Johnston, Western Director for National Right to Life and author of "Death as a Salesman," produced a video that aired in Maine about the dangers of assisted suicide and traveled around the state educating citizens about these dangers (National Right to Life News, 2000). Maine Right to Life wrote and distributed newsletters, produced another video that discussed the dangers of assisted suicide and educated citizens in rural Maine by sending speakers to discuss these dangers (National Right to Life News, 2000). The Catholic Church distributed pamphlets and video that educated citizens about the loopholes and flaws of the measure. Opponents also provided citizens with alternatives such as palliative care and hospice care. Smith said of the Maine Medical Association, "We also believed that the way to deal with the public concerns was to improve care at the end of life, particularly in the areas of pain control and hospice availability. Most persons would not choose an intentional death if they believed that they would be well treated and not in pain at the time of their natural death" (Smith, personal communication, 7-12-08).

Citizens of Maine did not approve "Question 1". The measure was defeated of 51.5% to 48.5% (International Taskforce, 2000). No Exit poll was found to determine how citizens voted according to religion, age, and gender.

During Maine's struggle to legalize physician assisted suicide, Angus S. King, Jr. was the Governor. He was the governor of Maine from 1995-2003. Maine's Death with Dignity initiative was seemingly not a big priority for Governor King. According to the Year 2000 Blue Ribbon Commission on Health Care, a five-member commission appointed by Governor King, Maine’s health care system was “inefficient, unreasonably complicated and unfair” (International Taskforce, 2000) . Maine’s Death with Dignity for many citizens was a response to this inefficiency and unfairness. Giving citizens the ability to choose how and when they die would give some an alternative to the inefficiencies of Maine’s healthcare system. The Blue Ribbon Commission believed that even with nearly 5 billion dollars spent yearly on health care in the state, Maine’s citizens could not receive the quality care they deserve. When simplified, the 5 billion dollars spent yearly in Maine on healthcare would translate to about $3, 500 per person (*Portland Herald Press*, 2000).

Chapter four described the ballot initiative efforts in Washington, California, Oregon, Michigan, and Maine to legalize physician assisted suicide. Each state’s description detailed some of its basic demographics; culture and diversity types of each state were discussed as well as the basic steps of the initiative process in each state, and the history of assisted suicide within each state including proponents and opponents of the initiatives was discussed. The descriptions also examined ways that the governor and interest groups exerted influence involved in each state’s initiative process. Exit poll data for California, Oregon, and Michigan that showed how citizens voted for the PAS initiative according to religion, age, and gender was presented as well. The next chapter of this research will analyze the case studies of the five states and make conclusions about this research as well as suggestions for future research.

CHAPTER 5: FINDINGS AND CONCLUSION

This section focuses on the study's findings and conclusions. I began the research by conducting a literature review which helped determine what information has already been stated on the topic of physician assisted suicide. As part of the literature review, I presented four theories of the political process that helped me understand what factors may influence policy change. By studying each theory and from previous research covered in the literature review, I was able to devise a list of six specific factors that may influence PAS initiatives. I determined the type of methodology appropriate for this study and then applied it to conduct the five case studies which allowed me to conduct a comparative analysis of Washington, California, Oregon, Michigan and Maine to determine what factors influenced Oregon's success and the other four state's failure.

From the information gleamed from the case studies, I was able to confirm and/or disprove the six hypotheses and ultimately answer the study's research questions. The basic question for this study asked: What factors contributed to Oregon's success and the defeat of the initiative in Washington, California, Michigan, and Maine? The six factors used to help answer these questions include governor influence, interest group influence, culture, religion, age, and gender.

Below table 5-1a/b outlines an overall view of the data found in each state for the six variables. Table 5-1c below outlines the six hypotheses and whether they were confirmed. Data from each factor is then presented that shows why each hypothesis was confirmed and/or disproved. For religion, age, and gender a chi-square analysis was conducted on available exit poll data to determine if the factor was significantly associated with physician assisted suicide.

Table 5-1a

Variables	Measures	Washington	California	Oregon	Michigan	Maine
Governor exertion of influence for PAS	Content analysis and Activities while in office to influence PAS	No exertion	No exertion	PAS not mentioned Endorsed PAS, Wrote Book	PAS not mentioned Signed Bill 200 prohibiting PAS	No exertion
Interest Group exertion of influence	For	For-1.6Mil	For-1.7Mil	For-600,000	For-1.2Mil	For-2Mil
	Against	Against- 1.9Mil	Against-1.9Mil	Against-1.5Mil	Against-5+Mil	Against-2 Mil
	Strategies	Both sides ran ads and educated citizens	Both sides ran ads and educated citizens	Both sides ran ads and educated citizens	Both sides ran ads and educated citizens	Both sides ran ads and educated citizens
Culture	Elazar	Moralist	Moralist-Individualist and Moralist-Traditionalist	Moralist	Moralist and Individualist-Moralist	Moralist
	Hero/ Tolbert	Homogeneous	Heterogeneous	Homogeneous	Homogeneous	Homogeneous

Table 5-1b

Vote by Religion	Exit poll data Protestant (y/n) Catholic (y/n) Other Christians (y/n)	No Exit Poll Data	Protestant (y-39% /n-61%) Catholic (y-44% /n-56%) Other Christians (y-44% /n -56%)	No Exit Poll Data	No Exit Poll Data	No Exit Poll Data
Vote by Age	Exit poll data 18-29 (y/n) 30-44 (y/n) 45-59 (y/n) 60 and over (y/n)	No Exit Poll Data	18-29 (yes-52%/ no-48%) 30-44 (yes-46%/ no-54%) 45-59 (yes-44%/ no-56%) 60 and over (yes-43%/ no-57%)	18-29 (y-63% / n-37%) 30-44 (y-49%/ n-51%) 45-59 (y-57%/ n-43%) 60 and over (y-44%/ n-56%)	18-29 (y-29%/ n- 71%) 30-44 (y-28%/ n- 72%) 45-59 (y-31%/ n-69%) 60 and over y-30%/ n- 70%	No Exit Poll Data
Vote by Gender	Exit poll data Male (y/n) Female (y/n)	No Exit Poll Data	Male (yes-50%/ no-50%) Female (yes-44%/ no-56%)	Male (yes-58%/ no-42%) Female (yes-46%/ no-54%)	Male (yes- 33%/ no-67%) Female (yes-26%/ no-74%)	No Exit Poll Data

Table 5-1c

Hypothesis	Measures	Confirmed/Not Confirmed
Governor Influence	State of State Address, media stories and interviews showing support and activities	Partially Confirmed
Interest Group Influence	Money and Mobilization Strategies	Partially Confirmed
Culture Diversity	Moralistic, Individualistic, Traditionalistic Heterogeneous, Homogeneous, Bifurcated	Not Confirmed
Religion	Total voting population Difference in voting between Protestant and Catholic voters	Partially Confirmed
Age	Total voting population Difference in voting between voters age 18-59 and voters 60 and older	Partially Confirmed
Gender	Total voting population Difference in voting between Males and Females	Confirmed

Governor

The first hypothesis states the greater the support and exertion of influence of the governor, the more likely his or her position on PAS is to pass. The hypothesis was partially confirmed. In Oregon, the only state to legalize physician assisted suicide, the governor supported physician assisted suicide and was married to the state senator who tried to pass three bills through the legislature to legalize assisted suicide in Oregon. Oregon's governor, Barbara Roberts did not sign a bill to legalize physician assisted suicide, but the initiative in Oregon did pass. Later Governor Roberts gave her support to California and Maine during their quest to legalize physician assisted suicide through an initiative. Washington's Governor Booth Gardner did not directly influence physician assisted suicide legislation during his tenure, but he is currently seeking to legalize assisted suicide by trying to get Initiative 1000 on Washington's ballot in November 2008. Data was not found on the position of California's Governor Peter Wilson on physician assisted suicide, and he did not seek to influence physician assisted suicide during his tenure. Of the five governors in this study, only one governor actively sought to criminalize physician assisted suicide. Michigan's Governor John Engler took the most proactive role to influence physician assisted suicide legislation. Governor Engler signed Senate Bill 200, making assisted suicide a felony. A position was also not found for Maine's Governor Angus King on physician assisted suicide, and he did not try to influence physician assisted suicide in Maine.

A content analysis was conducted on each of the governor's State of the State Addresses while they were in office to see if physician assisted suicide was on their agenda.

Even though John Engler signed legislation to criminalize physician assisted suicide, Barbara Roberts supported the practice while in office, and Booth Gardner is trying to get PAS on the ballot for a vote in the November 2008 election, they along with the governors of California or Maine did not mention physician assisted suicide in their speeches as a priority for their state.

Interest Group

The second hypothesis for this research states the greater the support and exertion of influence of a state's interest groups, the more likely their position on PAS is to pass. This hypothesis was partially confirmed. Data collected from the case studies showed that interest groups have influence over the initiative process. Interest groups can gain power and influence in a number of ways, but for this study their ability to generate and spend revenue and the strategies they used to affect policy were examined.

In Oregon, Measure 16 was sponsored by a group called Oregon Right to Die. They received $600,000 in funding and spent over $540, 000 on educating citizens on their right to choose assisted suicide and advertising. The Coalition for Compassionate Care opposed Oregon's Measure 16 and spent over $1.5 million educating citizens on the dangers of the measure and advertising. In Washington, Citizens for Death with Dignity sponsored Initiative 119 and spent around $1,734,100 trying to legalize assisted suicide through television ad campaigns promoting the measure and collecting signatures for the petition. 119 Vote No! opposed Initiative 119 and spent approximately $1.9 million trying to defeat Initiative 119 and Initiative 120 (a proposal on abortion). Members of 119 Vote No! went door to door educating citizens on the lack of safeguards of the measure and debating on television. In California supporters of Proposition 161 spent $1.7 million dollars trying to legalize assisted suicide by running television ads promoting assisted suicide. Proposition 161 was opposed by 135 groups, and they spent approximately $1.9 million in their efforts to defeat Initiative 119 and Initiative 120. In Michigan, Merian's Friends sponsored Proposal B and spent around $1 million, most of which was spent on trying to get Proposal B on the ballot through signature collection. Citizens for Compassionate Care opposed Proposal B and spent around $5 million to oppose the measure by running ads on the dangers of the proposal. In Maine, "Question 1" was sponsored by Death Dignity and spent around $2 million trying to get voters to approve their proposal to legalize assisted suicide through television ads. Maine Citizens Against the Dangers of Physician-Assisted Suicide opposed "Question 1" and spent almost $2 million dollars trying to defeat the measure by educating citizens about the dangers of the proposal by going door, through video, and mailings. Table 5-2 shows the money spent and strategies used to influence the PAS initiatives.

Table 5-2

Interest Groups	Washington	California	Oregon	Michigan	Maine
Money Spent					
For	1.6Mil	1.7Mil	600,000	1.2Mil	2Mil
Against	1.9Mil	1.9Mil	1.5Mil	5+Mil	2Mil
Strategies to Mobilize					
For	Advertising/ Educating Citizens	Advertising/ Educating Citizens	Advertising/ Educating Citizens	Advertising/ Educating Citizens	Advertising/ Educating Citizens
Against	Advertising/ Educating Citizens	Advertising/ Educating Citizens	Advertising/ Educating Citizens	Advertising/ Educating Citizens	Advertising/ Education Public Through Mailings and Video

As seen with the supporters and opponents of physician assisted suicide in each state, media coverage is very important. Media coverage may include television and radio ads, journals, internet, newspapers, and magazines. Though the costs of media coverage may vary by state, interest groups in this study used the media because it helped them communicate their message about physician assisted suicide to a large and diverse audience. This audience included professional associations, the general public, and legislators.

Research has shown that normally when running an initiative campaign and using the media, the group that spends the most money wins. However this was not the case in Oregon. Oregon's supporters spent \$600,000 whereas opponents spent \$1.5 million. Opponents' funding more than doubled the funding generated and spent by proponents of Measure 16. Of the five states, opponents of Proposal B in Michigan spent the most money (\$5 million) defeating the measure while supporters spent around \$1 million. In California, opponents also out spent proponents of physician assisted suicide, but not by as much money as in Michigan and were successful in defeating Proposition 161. In Maine, opponents and supporters spent around the same amount on their campaigns, but the opponents were successful in defeating "Question 1".

Much of Oregon's success may have come from how they ran their campaign. Proponents of Measure 16 were able to appeal to citizens emotionally throughout their campaign. They helped citizens understand they had a right to choose when and how they died. By focusing on the right to choose, proponents let citizens know that the terminally ill could avoid an embarrassing and long painful death, and that they could stop religious views from being imposed on them (Hillyard and Dombrink, 2001, p. 78). Ultimately proponents communicated that the decision would be that of the patient and not government (Hillyard and Dombrink, 2001, p. 78). Proponents also were successful perhaps because they learned that Washington and California's proposal may have been rejected partly because of a lack of safeguards. Measure 16 had a strategic element present that sought to counter the concerns found in Washington and California's proposals. Proponents wanted citizens to understand that assisted suicide is purely voluntary. As part of the safeguards, before being eligible to receive a lethal prescription, a patient must make two oral and one written request. However, there is 15 day waiting period between the oral requests and a 48 hour waiting period between the written request and actually receiving the prescription form the physician (Hillyard and Dombrink, 2001, p. 80).

Culture

The third hypothesis states that the more individualistic a state is, the more likely the initiative is to pass legalizing PAS. This hypothesis was not confirmed. Elazar's framework is a dominant way to look at culture, but it gives a simplistic view of culture and is limited. It does not take into account minorities and how they may affect policy processes and outcomes, and as a result, Hero and Tolbert's framework on social diversity was also used as another measure because it gives a more in depth way to look at culture. Of the five states that tried to pass physician assisted suicide initiatives, Oregon is the only state that was successful. After assessing Elazar and Hero and Tolbert's frameworks, the culture and diversity type for each state was determined. Results show that Oregon is a homogeneous state consisting of mainly a white ethnic diversity and has a moralist culture. Though the other states were not successful in passing their initiative, they also have a predominantly moralistic culture. Moralist states normally have greater policy innovation and propensity to change. However, citizens chose not to legalize PAS in Washington, California, Michigan, and Maine. Washington is a homogeneous state and has a moralist culture. California is a heterogeneous state and has a moralist-individualist and a moralist-traditionalist culture. Michigan is homogeneous and has a moralist and a moralist-individualist culture, and

Maine is homogeneous state and has a moralist culture. Though culture is a predictor of how states function politically, in this case there were other factors that influenced physician assisted suicide initiatives more than culture. Table 5-3 shows the culture and diversity type of each state.

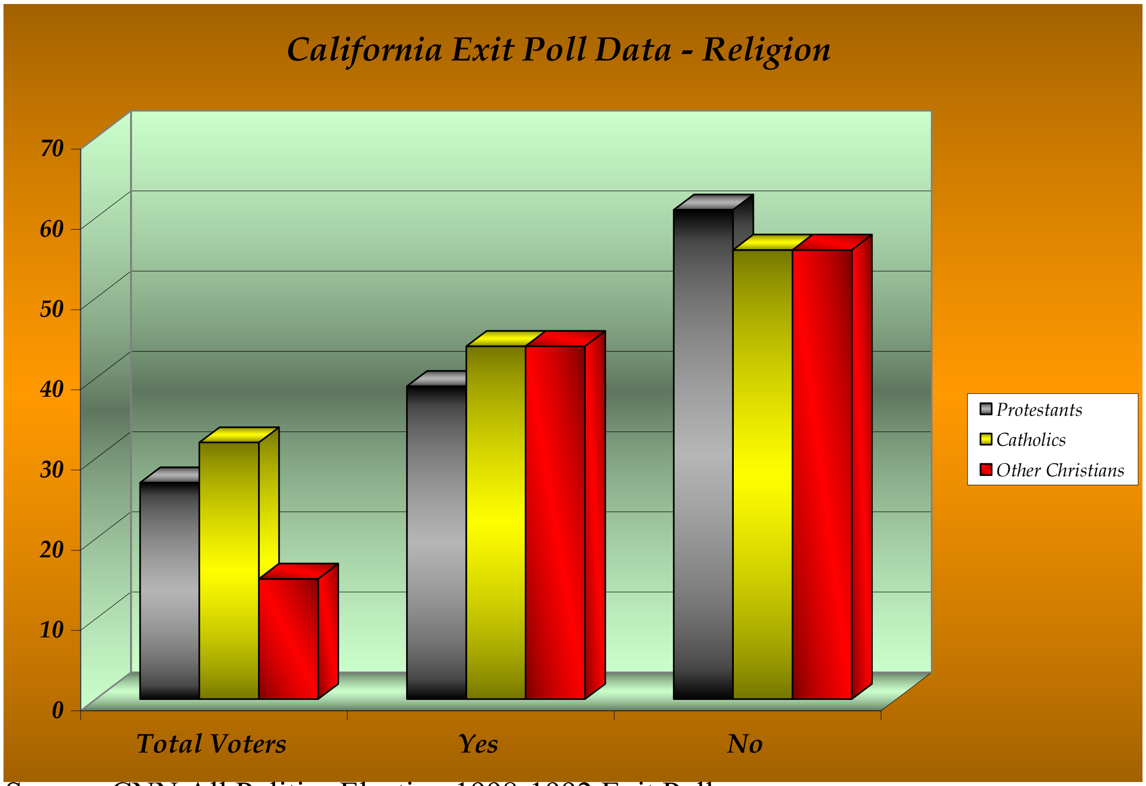
Table 5-3

State	**Culture**	**Diversity**
Oregon	Moralist	Homogeneous
Washington	Moralist	Homogeneous
California	Moralist-Individualist/Moralist-Traditionalist	Heterogeneous
Michigan	Moralist- Individualist/ Moralist	Homogeneous
Maine	Moralist	Homogeneous

Religion

The fourth hypothesis states that the greater the number of Catholic and Protestants that vote differently in a state, the less likely the initiative is to pass legalizing PAS. Often religion is a large indicator of how a person feels and votes about physician assisted suicide. Because exit poll data was only found for California to determine how citizens voted according to religion, analysis for religion is limited. Table 5-4 shows how citizens voted according to religion. Forty-four percent of Catholics voted Yes and 56% voted No. Thirty-nine percent of Protestants voted Yes and 61% voted No. Forty-four percent of other Christians voted Yes and 56% voted No. Jewish citizens accounted for 5% of the population, others accounted for 10% of the population, and non-religious accounted for another 11% of the population, but there was no data available in the exit poll on how these three populations voted.

Table 5- 4



Source: CNN All Politics Election 1998-1992 Exit Polls

A Chi square analysis was ran on data from California's exit poll to see if religion is significantly associated with physician assisted suicide. Table-5-5 shows the results of the chi square analysis on religion.

Table 5-5

California

	Yes	No	Total
Protestant	138	217	355
	149.59	205.41	
Catholic	185	236	421
	177.40	243.60	
Other Christians	87	110	197
	83.01	113.99	
Total	410	563	973

Chi-square = **2.445597**
df= 2
P is > .05
Conclusion = Religion is NOT significantly associated with physician assisted suicide

The hypothesis for religion was partially confirmed. Results show that religion is not statistically significant. However, past research on religion and physician assisted suicide has shown that religion does impact citizens' views on physician assisted suicide. For example, in a 2003 poll, Pew research showed that when questioned about a person's right to die and the term "suicide" is used, white evangelicals opposed 61%-29%, white Catholics opposed 47% to 45%, and mainline Protestants opposed 45% to 52%. The same study showed that religiosity is also strongly related to physician assisted suicide. Opposition for the practice came most from those who attended church regularly and said religion played an important role in their lives, and the policy was supported most by Americans who were not religious.

The findings on religiosity are confirmed in Oregon. According to Adherents.com, in Oregon where physician assisted suicide is legal, 17.2% of the population is not affiliated with a religion, which might be a plausible explanation why Measure 16 passed.

In this study, even though the analysis showed that religion was not significantly associated with physician assisted suicide, the results from the exit poll showed that Catholics and Protestants both opposed PAS more than they supported it, but Catholics opposed it more than Protestants.

Age

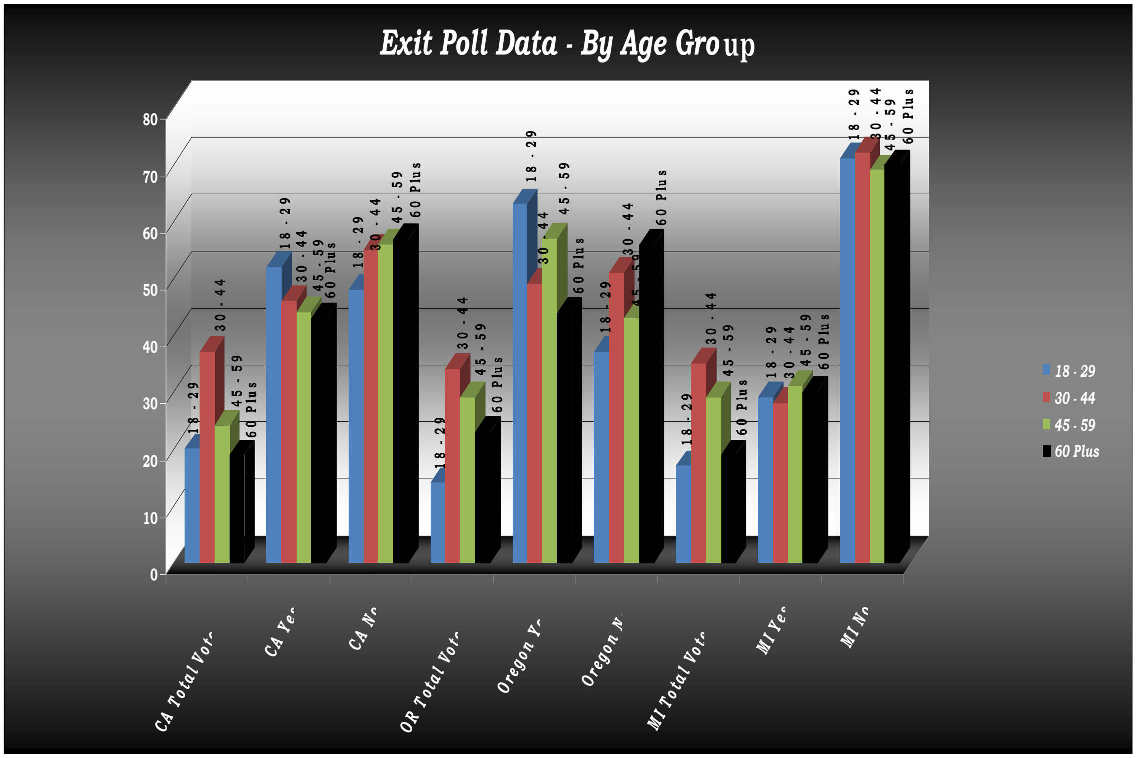
The fifth hypothesis states that the greater the number of voters 60 years and younger that vote differently from those 60 and older in a state, the more likely the initiative is to pass legalizing PAS. Pew and Roper polls have shown that age matters in regards to how a person feels about physician assisted suicide. Citizens 60 and younger tend to support the practice whereas their counterparts tend to oppose it.

Exit poll data was found for California, Oregon, and Michigan that showed the total voting population according to age and how each age group voted for PAS initiatives in their state. No exit poll data was found in Washington and Maine to determine how citizens voted according to age. Table 5-6 a/b shows the ages of citizens in each state and how they voted.

Table 5-6a

Age Groups	18-29	30-44	45-59	60+
California Total Voter	81%			19%
California Yes	52%	46%	44%	43%
California No	48%	54%	56%	57%
Oregon Total Voters	77%			23%
Oregon Yes	63%	49%	57%	44%
Oregon No	37%	51%	43%	56%
Michigan Total Voters	81%			19%
Michigan Yes	29%	28%	31%	30%
Michigan No	71%	72%	69%	70%

Table 5-6 b



Source: CNN All Politics Election 1998-1992 Exit Polls

In Oregon, citizens in the 18-29 and 45-59 age groups voted more in favor of PAS than their counterparts in the 30-44 and 60 and older age groups. In Oregon, there was a 19% difference between the 18-29 age group and those 60 and older who were not in favor of the practice, which supported the idea that citizens 65 and younger tend to support PAS more than their counterparts. In California only those in the 18-29 age group voted more in favor of PAS while those in the 30-44, 45-59, and 60 and older age groups opposed PAS more. The results in Michigan are also notable. Each of the four age groups all opposed PAS more than they favored it, and both the 18-29 and 30-44 opposed it more than the 60 and older age group.

The results showing citizens 59 and younger opposing PAS more than those 60 and older counters studies conducted on how age influences citizen's attitudes about physician assisted suicide. In 2000, The American Association of Retired Persons (AARP) conducted a national survey of people's attitudes about death and dying. The study found that "older people are less supportive of physician assisted suicide and voluntary active euthanasia than younger people, "while" younger people are more afraid of dying and being in pain at the end of life than older people" (Redfore, 2000).

Possible reasons why certain age groups hold the opinions they do about end of life issues were noted in AARP's study. Younger people did not want to prolong their life through the use of life support, and they were largely concerned about money and how their medical care could possible deplete their family finances (Redfore, 2000). Older people may possibly tend to be more opposed to physician assisted suicide because of maturity and life experiences. Senior scientist Dr. Powell Lawton from the Polisher Institute of the Philadelphia Geriatric Center stated that "People adapt over a lifetime to the ideas that there is such a thing as illness and disability, and that they can adjust to being ill or disabled and still find pleasure in life" (Redfore, 2000). Lawton believes that people are willing to endure more as they get older (Redfore, 2000).

A chi square analysis showed that age is significantly associated with physician assisted suicide. But the hypothesis was only partially confirmed because majority of the 59 and younger citizens in the three states opposed PAS more than they voted in favor of it. Because there was such a notable difference in how age groups voted in Michigan compared to California and Oregon other possible influences affecting PAS was explored later in this study.

Table 5-7 shows the results of the chi square analysis on age.

Table 5-7

Total

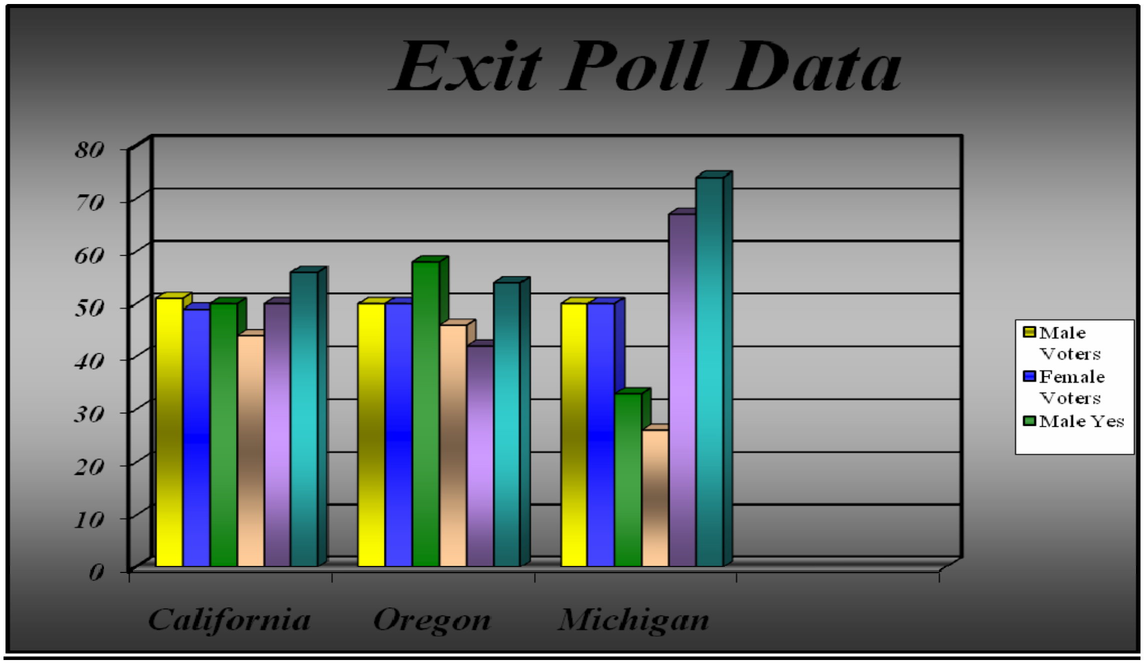
	Yes	**No**	**Total**
Age 18-29	303	339	642
	272.09	369.91	
Age 30-44	543	786	1329
	563.25	765.75	
Age 45-59	447	576	1023
	433.56	589.44	
Age 60+	298	462	760
	322.10	437.90	
Total	1591	2163	3754

Chi-square = **11.21035**
Df = 3
P is <.05
Conclusion = Age is significantly associated with physician assisted suicide

Gender

The sixth hypothesis states that the greater the number of males that vote differently than females in a state, the more likely the initiative is to pass legalizing PAS. In each of the five states, the percentage of men and women was very close. Exit poll data was found for California, Oregon, and Michigan. Males in Oregon accounted for half of the population and females accounted for the other half. Fifty-eight percent of males voted Yes and 42% voted No. Forty-six percent females voted Yes and 54% voted No. In California males accounted for 51% and females accounted for 49% of the population. Fifty-percent of males voted Yes and the other half voted No. Forty-four percent of females voted Yes and 56% voted No. In Michigan males accounted for half and females accounted for the other half of the population. Thirty-three percent of males voted Yes and 67% voted No. Twenty-six percent females voted Yes and 74% voted No. No Exit poll data was found in Washington and Maine to determine how citizens voted according to gender. Table 5-8 shows how citizens voted according to gender.

Table 5-8



Source: CNN All Politics Election 1998-1992 Exit Polls

In Oregon, males voted more in favor of PAS than females. In California, they also voted more in favor of PAS than their female counter parts, but in Michigan there was a departure from predicted voting patterns which states that males are more likely to vote in favor of PAS than females. Males and Females in Michigan significantly opposed and voted against physician assisted suicide. The hypothesis for gender was confirmed after a chi square analysis showed that gender is statistically associated with PAS and exit poll data showed that males did vote more in favor of PAS in two out of the three states where exit poll data was available.

Table 5-9 shows the results from the chi square analysis on gender.

Table 5-9

Total

	Yes	No	Total
Men	884	1007	1891
	55%	47%	50%
Women	716	1147	1863
	45%	53%	50%
Total	1600	2154	3754
	100%	100%	100%

P is < .05

Conclusion: Gender is significantly associated with physician assisted suicide

Of the six hypotheses tested, governor influence, interest group influence, religion, age, and gender were partially or fully confirmed and showed to have affected the outcomes of the PAS initiatives. Interest groups probably had the most influence while culture and religion had the least amount of influence. Interest groups had a large impact on the initiatives because they ran campaigns to support and/or oppose legalizing physician assisted suicide. As a part of these campaigns, interest groups whether they supported or opposed legalizing assisted suicide, raised money and aired radio and television ads supporting their position. Additionally, supporters educated citizens on their right to choose while opponents educated citizens on possible dangers of physician assisted suicide through mailings, video, television ads, debates, and going door to door speaking to citizens. Opponents also advocated alternatives such as palliative care instead of assisted suicide.

The amount of influence each interest group had may have also been determined by social diversity and the type of culture in each state. Hero (1998) believes that social diversity not only influences political processes and outcomes, but also helps determine the power or strength of interest groups (p. 60). In homogeneous states where there is more of a consensus, interest groups tend to be weak. In bifurcated states where minority diversity is high and there is a need to maintain status quo, interest groups tend have moderate influence, and in heterogeneous states where many interests conflict and compete, interest groups tend to be stronger (Hero, 1998, p. 60).

Culture may have possibly impacted interest group influence, but overall had the least amount of impact on PAS outcomes because it was hypothesized that states most likely to pass PAS initiatives are individualistic and results showed that all five states were predominantly moralistic. Oregon, where PAS is legal is moralistic.

A chi square analysis conducted on exit poll data from California, Oregon, and Michigan found that age and gender were statistically associated with PAS while religion was not. However, results from the exit polls also showed that although age has an impact of physician assisted suicide, voting patterns according to age are not always predictable because many citizens 59 and younger in California, Oregon, and Michigan voted against PAS more than they voted in favor of it.

Religion possibly was not statistically associated with PAS because exit poll data on religion was only found for California. Had data been found for the other four states, religion may have had a greater influence on PAS.

Study's Strengths

Several strengths are noted from this study. First, there were only five states that tried to legalize PAS through initiatives and all of those states were included in this study. Second, this research added to the body of knowledge on PAS initiatives.

Third, based on the archival data and interviews with interest groups, a richer discussion on the issues under review was provided. Fourth, even though the study identified six specific factors that may have influenced PAS initiatives, other possible factors were identified that may have been influential and can add to suggestion for future study.

Study's Limitations

This research noted several limitations. First, the initiative process to legalize physician assisted suicide was only examined in five states and the results will be generalized for other U.S. states. Second, six factors were examined to determine their influence on the physician assisted suicide initiative process, but because physician assisted suicide is such a complex phenomena, there are other factors that may have influenced Oregon's success and Washington, California, Michigan, and Maine's failure. According to Flick (2006), "Most phenomena cannot be explained in isolation, which is a result of its complexity in reality" (p. 15). Third, exit poll data was not found for Washington and Maine to determine if there was any statistical significance among religion, age, and gender. Additionally, even though exit poll data was found for California, Oregon, and Michigan, only California had data on religion, which may have adversely impacted religion's association with physician assisted suicide. Fourth, because the governors and many key lawmakers have left office since the initiative in their state was proposed, they were unavailable for interviews.

Lastly, due to limited time, resources, and lack of response from some of the targeted interest groups, not all groups were interviewed so that the researcher could get better insight into their initiative campaigns.

Other Possible Influences on Physician Assisted Suicide Initiatives

Of the six hypotheses tested, interest groups and their mobilization strategies possibly had the greatest influence on the physician assisted suicide initiatives. However, there are other possible reasons that may have influenced why the initiatives were successful in Oregon and not in the other states. For example, in Washington, Initiative 119 may not have passed because of Jack Kevorkian. Even with Jack Kevorkian living in Michigan, his influence was far reaching. On October 28, 1991, 11 days before Washington's vote for Initiative 119, he assisted two people with ending their lives. Media coverage of Kevorkian's actions continued for days, and people in Washington became concerned. They wondered what type of affect would Kevorkian's actions have on their state and if the same type of suicides would happen in Washington (Humphry, 1993, p. 97).

Though Kevorkian's actions may not have had a direct affect in California, an implication of Kevorkian's actions was that citizens in states where initiatives were proposed began to really ponder the affects that legalizing physician assisted suicide may have on their lives. In California, citizens were affected by the ads that opposed Proposition 161. People who survived cancer were in ads, and they spoke on the value of life. Through these ads, citizens considered how Proposition 161 would change things in California. Specifically, they saw how it would "reshape medicine, by shifting it from an art of healing to a licensed dispatching service" (Jordan, 1992). Additionally, many argued that there were alternatives to physician assisted suicide, such as effective pain management. Through effective pain management life could be tolerable and desirable. Too few safeguards may have also been another possible reason why physician assisted was not legalized in Washington and California.

Oregon's success with Measure 16 possibly occurred because of Patty Rosen's testimony about having aided in her daughter's death. Rosen testified that she administered an overdose of pills to kill her daughter. Rosen's account of the details surrounding her daughter's death was later found to be untrue. Another possible explanation for Oregon's success was the resiliency of the citizens. Measure 16 was challenged in court after citizens voted to pass the measure. Some may have disliked having to vote a second time on an initiative that had already passed. This move by the Legislature to repeal Measure 16 set a precedent (Kamisar, 1999, p. 1). The Legislature had never repealed an initiative passed by voters.

In Michigan, where the measure was overwhelmingly defeated 71%-29%, there are many possible reasons for such a large defeat. Many citizens did not approve of Dr. Jack Kevorkian's actions, and did not want to legalize phyician assisted suicide and so they may have possibly rebelled and voted against the measure. According to a December 4-6, 1993 Gallup poll, 47% of citizens did not approve of Kevorkian's actions whereas 43% did approve, and 10% had no opinion (Gallup, 2000, p. 162). In another poll conducted on March 12-14, 1999, four months after the 1998 election where Michigan's Proposal B was defeated, approval for Kevorkian increased nine points to 52% (Gallup, 2000, p. 162). Strangely enough, even though Kevorkian endorses physician assisted suicide, he did not support Proposal B. Kevorkian stated that he has attended more than 120 deaths but considered Proposal B too restrictive and regulatory; he called the measure "crazy" (Death with Dignity National Center, 2006). Proposal B was opposed by Citizens for Compassionate Care, and they raised around $5 million to defeat Proposal B. Proponents of Proposal B only raised around $1 million. Opponents spent five times more than supporters of Proposal B, so the effectiveness of the ads and the educational campaign launched by opponents may have also contributed to Proposal B's defeat. Supporters of Proposal B stated that their opponents had better funding and overwhelmed them with ads (Kamisar, 1999, p. 1). The measure could have also failed because Proposal B loosely defined physician assisted dying and the proposal had very broad language (Death with Dignity National Center, 2006). Dr. John Finn, Hospice of Michigan's executive director and part of the coalition against Proposal B believed that Proposal B was defeated because of voter education from the opponents. Finn stated, "Voters were against the legislation itself, not against physician assisted suicide. It may have been a different outcome if they had a very open-ended piece of legislation that would be accessible to all suffering patients, not just the terminally ill" (Death with Dignity National Center, 2006). Citizens in Michigan like those in Washington and California may have pondered the affects of Proposal B along with possible dangers. They may have also pondered whether there were too many safeguards or not enough, and how it might affect them and their family members. Many radio and television ads noted how newspapers warned citizens about possible dangers of abuse. They noted insurance companies, managed care, and Medicaid could possibly reduce and cut treatments for terminally ill patients if assisted suicide became a legal option.

This change would force patients into death rather than allow the choice to be voluntary. Part of the opponent's education campaign in Michigan was letting citizens know that physicians would have to lie about the cause of death on a patient's death certificate by stating that the patient died of a terminal illness instead of assisted suicide. Additionally, the campaign noted that there would be a lack of disclosure to the public about the implementation of the assisted suicide proposal. This was particularly disturbing because if anything went wrong with implementation or the proposed safeguards were not effective, citizens may not have ever known something was wrong until they were personally affected. Michigan citizens may have also been concerned because some residents did not have health insurance, and may have confirmed one of the criticisms against physician assisted suicide. As previously stated, some critics of physician assisted suicide opposed the practice because they believed that abuse may occur because disenfranchised groups such as minorities, disabled, and uninsured might be forced to prematurely end their lives. Michigan citizens also wanted the state to focus on alternatives to assisted suicide such as effective pain management and hospice care.

In Maine, "Question 1" may have been defeated because of the educational component in the opponent's campaign. Opponents of "Question 1" wanted to educate citizens about the dangers of the measure. They educated citizens as they worked with the media to speak against the proposal and answered questions for the public; they publicly debated supporters of "Question 1", and attended meetings about healthcare. According to Gordon Smith, the executive vice President of Maine's Medical Association, one of the opponents for "Question 1", the legislative act to enact the Maine Death with Dignity Act was a "radical proposal, fraught with legal difficulties" (Hillyard and Dombrink, 2001, p. 215). Smith believed that the proposal would have a negative effect on physicians since their primary job is to save lives, not end them. He also feared the slippery slope argument where there would be a push for non-voluntary euthanasia (Hillyard and Dombrink, 2001, p. 215). Additionally, Smith believed that more physicians in Maine were being trained in palliative which showed that there is an increased concern to effectively manage and when possible eliminate patients from pain (Hillyard and Dombrink, 2001, p. 215). The Maine Osteopathic Association argued that if physician assisted suicide was an available option, the use of alternatives such as hospice would decrease and could hinder the progress of finding other options such as palliative care (Hillyard, 2001, p. 215). The quality of healthcare in Maine may have also contributed to the measure's defeat. According to a report by the Year 2000 Blue Ribbon Commission on Health Care, a commission appointed by Maine's governor, Angus King, in spite of the $5 billion dollars spent every year on Healthcare in the state, many of Maine's citizens cannot receive quality healthcare (International Taskforce, 2000). Many citizens in Maine do not seek out medical attention because of the high cost and those with insurance do not because of high deductibles (*Portland Press Herald*, 2000). If physician assisted suicide were an option in Maine, many citizens may feel that due to the poor quality but high cost of healthcare, it would be their best alternative because a lethal prescription may cost around $75 (International Taskforce, 2000). Seventy-five dollars for a prescription is cheaper than surgery, chemotherapy or even hospice.

Future Study

Each of the five states tried to legalize physician assisted suicide through the legislative process in addition to the initiative process. Future study can be conducted that closely examines the legislative process and compare that to the initiative process to determine if there are factors that are unique to each process that influences the outcome of physician assisted suicide policy. Additionally, not all active interest groups or any key law makers and family members of patients who may have been affected by physician assisted suicide were interviewed, but given more time and resources they could be interviewed and information taken from the interviews can add to the list of factors that may have influenced the PAS initiatives in each state. Future study may also include interviews with and an in depth study of Dr. Jack Kevorkian because many of his actions influenced how citizens voted on the initiatives, but also his actions influenced legislation passed in Michigan prohibiting assisted suicide. Of all the five states that tried to legalize assisted suicide through an initiative, Michigan's initiative had the largest defeat, 79%-21%. Future study may examine specific influences of Michigan's outcome. More study on the media and their influence on the initiative process can be studied as well. As seen through the case studies, interest groups buy media time as a strategy to help influence policy change, and the media is responsible for providing information to citizens and affecting public opinion through this information. It is also important to look at diversity and culture in the future. Even though it was hypothesized that individualistic states are more likely to legalize PAS, most of the states were predominantly moralistic, thus leaving the question, why are moralistic states more likely to legalize PAS policy than individualistic or traditionalistic states?

Along with culture, age can be added as a future topic for study to determine if and why citizen's opinions and how they vote about PAS changes earlier than previously suggested.

Conclusion

The ethical, moral, and legal aspects of physician assisted suicide have been extensively debated. There are many who support the practice as well as many who oppose it. For most, their position on physician assisted suicide has been determined by life experiences and personal characteristics. For example, those who have lost loved ones due to terminal illnesses and/or are suffering from an illness themselves may have a totally different position than someone who is not ill or has not been closely affected by the death of someone terminally ill. Also someone 62 years old and a devout Catholic may have a different position than someone who is 25 and not affiliated with a religion. It is clear that the physician assisted suicide debate will continue as laws change and more people are confronted with terminal illnesses.

Many may see Oregon as an anomaly because of its success in legalizing physician assisted suicide, and other states will continue to copy the actions of Oregon and use the initiative process to try and legalize physician assisted suicide.

Because Oregon was successful at legalizing physician assisted suicide and Washington, California, Michigan, and Maine were not, this research attempted to answer several questions: 1) What factors contributed to Oregon's success and the defeat of the initiatives in Washington, California, Michigan, and Maine? Of the six factors used to answer this question, results from the study show that governors, interest groups, religion, age, and gender influenced the outcomes of the PAS initiatives. 2) Why did citizens use the initiative process to legalize PAS? The initiative process is a bridge between policy and the preferences of citizens. Most often when legislators are unresponsive to citizens, the initiative process is used to make policy that favors citizens' preferences. 3) Who were key actors in the PAS movement? Governors, legislators, interest groups, the courts, citizens, patients and their families were key actors in the PAS movement. 4) What role did the governors, legislators, and interest groups play in the passage or failure of the initiative in each state? In Oregon and Michigan the governors were vocal about their position on physician assisted suicide. Oregon's Governor Barbara Roberts supported physician assisted suicide and traveled to other states advocating for the practice even though she did not sign legislation to legalize the practice. Her husband was a state senator who died of cancer, but while in office, he tried to pass three bills that would legalize PAS, all were unsuccessful. In Michigan, Governor John Engler took a more proactive role against physician assisted suicide. He signed a bill that the state Senate and House of Representatives passed that was sponsored by Sen. William Van Regenmorter banning a person from helping another die. In Washington, Governor Booth Gardner did not actively seek to influence PAS legislation during his tenure, but he has Parkinson's disease and is currently seeking to get I-1000, a measure that will legalize PAS on the ballot for November 2008. Interest groups in all five states were active in their role trying to legalize or stop the legalization of physician assisted suicide. Each group raised funds to run their ad campaigns. Those that supported the practice advocated that citizens have a right to choose when and how they die. They advertised on the radio and through television ads. Those who opposed it mainly focused their campaigns on the dangers and lack of safeguards for the proposed measures and tried to educate citizens through television ads, debates, mailings, and going door to door. Interest groups had a large impact on PAS policy because ultimately, they sponsored the campaigns for and against the proposed physician assisted suicide initiatives, gathering signatures from citizens to get the initiatives on the ballot. Through media time and organized activities they were able to influence public opinion. In turn, citizens used their opinion about physician assisted suicide to help guide how they voted on Election Day. 5) Contextually, what role does state demographics play in PAS movement? Demographics such as religion, age, and gender are significant to the movement because these factors often affect how relevant or important physician assisted suicide is to citizens and how they vote on such an issue. For example, as seen, those who identify with a particular religion and see religion as an important part of their life tend not to support PAS and usually vote against it. In the same manner males usually support PAS and vote more in favor of it than females.

Significant discoveries were made in this research which may help change the way some of the variables were previously viewed. For example, because culture was not confirmed, I had to dig deeper to determine what other dimensions I may find out about culture. The results give credence to the moralistic culture because the dominant culture in Oregon where PAS was legalized was moralistic as well as in each of the other four states. As noted, moralistic states have greater policy innovation and a greater propensity for change, but they also are more tolerant than other cultures because their main focus is commonwealth and what is best for the citizen. Additionally, by results showing that citizens 59 and younger opposed PAS more than they favored it may suggest that the age that citizen’s opinions and how they vote on issues like PAS may change earlier than previous research has suggested. Not only do the findings give a new way to look at some of the variables in this study, but they also give more knowledge about the type of governors, interest groups, cultures, religions, age groups as well as which gender are more likely to support PAS or influence the outcomes of PAS initiatives.

If major institutions and citizens are to accept and support physician assisted suicide and euthanasia as end of life alternatives, there must be effective safeguards in place to ease the minds of citizens that fear abuse. Appropriate legislation must also be in place to enforce these safeguards. In each of the five states studied in this research, the opponents were concerned about the dangers and lack of safeguards of each measure. Whether or not the practice is legalized in states other than Oregon, medical professionals must also devise new and more effective methods for accurately diagnosing and caring for the terminally ill. Some argue that palliative care is a viable option for terminally ill patients. However, more research must be conducted to determine if palliative care is a suitable option, but also more alternatives must be provided for patients. Supporters of physician assisted suicide have increased their support base and will continue to do so by educating and helping citizens understand that they should have options, and they have the right to choose the best end of life care for them.

Epilogue

Three days before defending my dissertation, on November 4, 2008, citizens in Washington State voted in favor of Initiative 1000 legalizing physician assisted suicide.

The law asks, “Who should decide these difficult end-of-life questions?” (Death with Dignity, 2008) Initiative 1000, Washington’s death with dignity law is very similar to Oregon’s law and has numerous safeguards in place to protect citizens from abuse. These safeguards include two waiting periods, an independently witnessed oral and written request, confirmation of mental competency by two physicians, and a requirement that only the patient can administer the medicine to end his or her life (Death with Dignity, 2008). Supporters of the measure felt that terminally ill patients who are suffering great pain should have the choice to hasten their deaths in a “humane and dignified” manner (Tu, 2008). Opponents felt that there is no need for assisted suicide because pain can be effectively managed due to the advancement of end of life care. Opponents also felt that even though the measure has safeguards, there is no real way of knowing if they are effective because most cases provide limited information to the public (Tu, 2008). Supporters of Initiative 1000 spent around $4.9 million dollars whereas opponents spent around $1.6 million dollars (Tu, 2008). Washington’s former Governor Booth Gardner was a big supporter of the measure and was able to exert influence by giving $750,000 of his and his extended family’s money to support the measure. Gardner also spoke out in the media often about his support for legalizing assisted suicide. Gardner said, “People have the right to have control over the final days of life” (Iwasaki, 20008).

It seems more reasonable that Initiative 1000 would pass seventeen years later because former Governor Booth Gardner endorsed PAS and actively sought to get the measure on the ballot and interest groups who supported PAS ran effective ad campaigns and outspent their opponents. More importantly it seems reasonable that the measure passed because it mirrors Oregon’s Measure 16 and has added safeguards that were not present in Initiative 119, Washington's 1991 proposal to legalize assisted suicide. Many citizens may desire to have the right to make end of life choices, but when options like assisted suicide are available without measures to ensure safety, citizens may not be so apt to favor the legalization of such an option. One of the most notable safeguards between Initiative 119 and Initiative 1000 is that Initiative 119 would have allowed doctors to write and administer the lethal prescription to patients and Initiative 1000 does not. As previously stated, many that oppose PAS feel that the practice compromises the oath that physicians take to save lives. By not allowing the physician to administer the prescription, the patient is given full autonomy over when and if he or she will take the prescription, thus absolving the physician of any violations or infractions.

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APPENDICES

Appendix A

Legal Status of Assisted Suicide/Euthanasia in the United States

Details and Documentation

	Current State Statutes	Past & Pending Legislation	Court Cases
Alabama	Alabama has no law which specifically prohibits assisted suicide. It is believed that extreme cases may be prosecuted as manslaughter. Ala. Code §13A-6-3 (Michie, LEXIS through 2000 Legis. Sess.). Euthanasia is prohibited in Alabama under the general homicide laws.	Proposed legislation to legalize physician-assisted suicide in Alabama died on the floor of the Senate in 2000 and 2001.	One favorable court decision.
Alaska	Alaska has a law which specifically prohibits assisted suicide. Alaska Stat. §11.41.120 (LEXIS through 2000 legislation). Euthanasia is prohibited in Alaska under the general homicide laws.		In 2001, the Alaska Supreme Court unanimously declared in the case of *Sampson v. Alaska* that the Alaska law prohibiting assisted suicide is valid under the Alaska Constitution.
Arizona	Arizona has a law which specifically prohibits assisted suicide. Ariz. Rev. Stat. §13-1103 (LEXIS through 2000 legislation). Euthanasia is prohibited in Arizona under the general homicide laws.		
Arkansas	Arkansas has a law which specifically prohibits assisted suicide. Ark. Code Ann. §5-10-104 (Michie, LEXIS through 2000 legislation). Euthanasia is prohibited in Arkansas under the general homicide laws.	Proposed legislation to legalize physician-assisted suicide in Arkansas was introduced in 2001 and then withdrawn. Legislation was passed in Arkansas in 1999 to create a criminal offense for physician-assisted suicide.	
California	California has a law which specifically prohibits assisted suicide. Cal. Penal Code §401 (Deering, LEXIS through 2000 Legis. Sess.). Euthanasia is prohibited in California under the general homicide laws.	In 1992, the citizens of California defeated a ballot measure to legalize physician-assisted suicide using lethal injection by a 54%-45% margin. Proposed legislation introduced in 2000 to legalize physician-assisted suicide in California received a favorable vote in a House committee but did reach the floor for a vote of the full House.	
Colorado	Colorado has a law which specifically	In 2000, a petition to the Colorado	

	prohibits assisted suicide. Colo. Rev. Stat. §18-3-104 (LEXIS through 2000 Legis. Sess.). Euthanasia is prohibited in Colorado under the general homicide laws.	Court of Appeals to legalize physician-assisted suicide in Colorado through a court ruling failed.
Connecticut	Connecticut has a law which specifically prohibits assisted suicide. Conn. Gen. Stat. Ann. §53a-56 (LEXIS through 1999-2000 Legis. Sess.). Euthanasia is prohibited in Connecticut under the general homicide laws.	
Delaware	Delaware has a law which specifically prohibits assisted suicide. Del. Code Ann. tit. 11, §645 (LEXIS through 2000 Legis. Sess.). Euthanasia is prohibited in Delaware under the general homicide laws.	
District of Columbia	The District of Columbia has no law which specifically prohibits assisted suicide. It is possible that assisted suicide is prohibited under the common law. D.C. Code Ann. §22-107 (LEXIS through D.C. Reg. 06/30/2000). Euthanasia is prohibited in the District of Columbia under the general homicide laws.	
Florida	Florida has a law which specifically prohibits assisted suicide. Fla. Stat. § 782.08 (LEXIS through 2000 Legis. Sess.). Euthanasia is prohibited in Florida under the general homicide laws.	In 1997, the Florida Supreme Court upheld the Florida anti-assisted suicide law under the Florida Constitution in *Krischer v. McIver*, 697 So.2d 97 (Fla. 1997).
Georgia	In 1994, Georgia enacted a law that specifically prohibits assisted suicide. Ga. Code Ann. §16-5-5 (LEXIS through 2000 Legis. Sess.). Euthanasia is prohibited in Georgia under the general homicide laws.	In 1996, Georgia passed a law to prohibit assisted suicide.
Hawaii	Hawaii has no law which specifically prohibits assisted suicide. Euthanasia is prohibited in Hawaii under the general homicide laws.	In 2002, Legislation was proposed and defeated to legalize assisted suicide in Hawaii.
Idaho	Idaho has no law which specifically prohibits assisted suicide. It is possible that assisted suicide is prohibited under the common law. Idaho Code §18-303 (Michie, LEXIS through 2000 Legis. Sess.) (generally recognizing common law offenses as crimes.) Euthanasia is prohibited in Idaho under the general homicide laws.	
Illinois	In 1993, Illlinois effectively penalized assisted suicide. 720 Ill. Comp. Stat. Ann. §5/12-31 (a) (2) (West, LEXIS through 2000 Act 91-954). Euthanasia is prohibited in Illinois under the general homicide laws.	

Indiana		Indiana has a law which specifically prohibits assisted suicide. Ind. Code Ann. §35-42-1-2.5 (Michie, LEXIS through 2000 Sess.). Euthanasia is prohibited in Indiana under the general homicide laws.	
Iowa		In 1996, Iowa enacted a law that specifically prohibits assisted suicide. Iowa Code Ann. § 707A.2 (LEXIS through 2000 legislation). Euthanasia is prohibited in Iowa under the general homicide laws.	
Kansas		In 1993, Kansas enacted a law that specifically prohibits assisted suicide. Civil penalties were added in 1998. Kan. Stat. Ann. § 21-3406 (LEXIS through 2000 Supp.). Euthanasia is prohibited in Kansas under the general homicide laws.	
Kentucky	Kentucky has a law which specifically prohibits assisted suicide. If a person commits an assisted suicide, he or she can be charged with a criminal act or can be assessed a penalty not considered as a criminal act. Ky. Rev. Stat. Ann. § 216.302 (Michie, LEXIS through 2000 Sess.). Euthanasia is prohibited in Kentucky under the general homicide laws.		In 1994, Kentucky passed a law prohibiting assisted suicide.
Louisiana		Louisiana has a law which specifically prohibits assisted suicide. La. Rev. Stat. Ann. §14:32.12 (West, LEXIS through 1999 Sess.). Euthanasia is prohibited in Louisiana under the general homicide laws.	
Maine	Maine has a law which specifically prohibits assisted suicide. Me. Rev. Stat. Ann. tit. 17-A, §204 (West, LEXIS through 2000 Supp.). Euthanasia is prohibited in Maine under general homicide laws.		In November of 2000, the citizens of Maine defeated a ballot measure to legalize physician-assisted suicide by a 51.5% to 48.5% margin.
Maryland	In 1999, Maryland enacted a law that specifically prohibits assisted suicide. Md. Code Ann. art. 27 § 416 (LEXIS through 2000 Sess.). Euthanasia is prohibited in Maryland under the general homicide laws.		In 1995 and 1996, proposed legislation to legalize assisted suicide was defeated in Maryland.
Massachusetts		Massachusetts has no law which specifically prohibits assisted suicide. It is possible that assisted suicide is prohibited under the common law, but the basis for a violation of common law does not clearly involve assisted suicide. *Commonwealth v. Mink*, 123 Mass. 422 (1877). Euthanasia is prohibited in Massachusetts under the general homicide laws.	
Michigan	Michigan has a law which specifically prohibits assisted suicide. Mich. Comp. Laws Ann. §750.329a (LEXIS through 2000 legislation). Euthanasia is prohibited in	In November of 1998, the citizens of Michigan defeated a ballot measure to legalize physician-assisted suicide by a 71% to 29% margin.	In 1994, the Michigan Supreme Court ruled that there is no federal constitutional right to assisted suicide in *People v. Kevorkian*, 527 N.W.2d 714 (1994).

	Michigan under the general homicide laws.	
Minnesota	Minnesota has a law which specifically prohibits assisted suicide. If a person commits an assisted suicide, he or she can be charged with a criminal act or be assessed a penalty not considered as a criminal act. Minn. Stat. Ann. §609.215 (LEXIS through 2000 legislation). Euthanasia is prohibited in Minnesota under the general homicide laws.	
Mississippi	Mississippi has a law which specifically prohibits assisted suicide. Miss. Code Ann. §97-3-49 (LEXIS through 2000 Legis. Sess.). Euthanasia is prohibited in Mississippi under the general homicide laws.	
Missouri	Missouri has a law which specifically prohibits assisted suicide. Mo. Rev. Stat. §565.023 (LEXIS through 2000 Legis. Sess.). Euthanasia is prohibited in Missouri under the general homicide laws.	
Montana	Montana has a law which specifically prohibits assisted suicide. Mont. Code Ann. §45-5-105 (LEXIS through 2000 Sess.). Euthanasia is prohibited in Montana under the general homicide laws.	
Nebraska	Nebraska has a law which specifically prohibits assisted suicide. Neb. Rev. Stat. Ann. §28-307 (Michie, LEXIS through 2000 Sess.). Euthanasia is prohibited in Nebraska under the general homicide laws.	Proposed legislation to legalize physician-assisted suicide has been introduced in every legislative session but no action has been taken by the state legislature.
Nevada	Nevada has no law which specifically prohibits assisted suicide. Euthanasia is prohibited in Nevada under the general homicide laws.	
New Hampshire	New Hampshire has a law which specifically prohibits assisted suicide. N.H. Rev. Stat. Ann. §630:4 (LEXIS through 2000 Sess.). Euthanasia is prohibited in New Hampshire under the general homicide laws.	In 1999, the New Hampshire Senate defeated proposed legislation to legalize physician-assisted suicide in New Hampshire.
New Jersey	New Jersey has a law which specifically prohibits assisted suicide. N.J. Stat. Ann. §2C:11-6 (West, LEXIS through 2000 Sess.). Euthanasia is prohibited in New Jersey under the general homicide laws.	
New Mexico	New Mexico has a law which specifically prohibits assisted suicide. N.M. Stat. Ann. §30-2-4 (Michie, LEXIS through 2000 Legis. Sess.). Euthanasia is prohibited in New Mexico under the general homicide laws.	
New York	New York has a law which specifically prohibits assisted suicide. N.Y. Penal Law §125.15 (McKinney, LEXIS through Ch. 49, 06/06/2001). Euthanasia is prohibited in New York under the general homicide laws.	The U.S. Supreme Court upheld the New York anti-assisted suicide law under the U.S. Constitution in *Vacco v. Quill*, 117 S. Ct. 2293 (1997).

North Carolina	North Carolina has no law which specifically prohibits assisted suicide. It is possible that assisted suicide is prohibited under the common law. N.C. Gen. Stat. §14-1 (LEXIS through 2000 Sess.). Euthanasia is prohibited in North Carolina under the general homicide laws.	In 1999, proposed legislation to prohibit physician-assisted suicide in North Carolina passed in the Senate but not the Assembly.	*State v. Willis*, 255 N.C. 473, 121 S.E. 2d 854 (1961), found attempted suicide to be a criminal offense.
North Dakota		North Dakota has a law which specifically prohibits assisted suicide. If a person commits assisted suicide, he or she can be charged with a criminal or be assessed a penalty which is not considered a criminal act. N.D. Cent. Code §12.1-16-04 (LEXIS through 1999 Legis. Sess.). Euthanasia is prohibited in North Dakota under the general homicide laws.	
Ohio		In 2002, Ohio Amended Substitute House Bill No. 474 became law. It amends §§ 4723.28, 4730.25, 4731.22 and 4761.09 and enacts §§ 37595.01, 3795.02, and 3795.03 of the Ohio Revised Code to declare that assisted suicide is against the public policy of Ohio, to provide for injunctive relief and attorneys fees against assisted suicide, and to create the Compassionate Care Task Force to study and make recommendations on treatment of intractable pain.	*Blackburn v. State*, 23 Ohio St. 146 (1872), may indicate that assisted suicide is prohibited under the common law.
Oklahoma		Oklahoma has a law which specifically prohibits assisted suicide. If a person commits an assisted suicide, he or she can be charged with a criminal act. In 1998, civil penalties were added. Okla. Stat. tit. 63, §§ 3141.1 to 3141.8 (LEXIS through 2001 Supplement). Euthanasia is prohibited in Oklahoma under the general homicide laws.	
Oregon	Oregon has a law which specifically authorizes physician-assisted suicide, enacted by the citizens of Oregon through a ballot measure in November of	In November of 1994, the citizens of Oregon legalized physician-assisted suicide through a ballot measure by a vote of	In November of 2001, United States Attorney General John Ashcroft ruled that using federally controlled substances to carry out

	1994. The new law was created through an exception to Oregon's general law which prohibits physician-assisted suicide. Or. Rev. Stat. §163.125 (LEXIS through 1999 legislation). Euthanasia is prohibited in Oregon under the general homicide laws.	51% to 49 %. In November of 1997, the citizens of Oregon rejected a ballot measure to overturn Oregon's law allowing physician-assisted suicide by a vote of 60% to 40%.	physician-assisted suicide was a violation of the federal Controlled Substances Act. Ashcroft's ruling was immediately challenged by the state of Oregon in *State of Oregon v. Ashcroft*, CV 01-1647 (D. Oregon), and federal court judge, Robert E. Jones, allowed Oregon's law to remain in effect pending judicial review.
Pennsylvania	Pennsylvania has a law which specifically prohibits assisted suicide. 18 Pa. Cons. Stat. §2505 (LEXIS through 2000 Act 86). Euthanasia is prohibited in Pennsylvania under the general homicide laws.		
Rhode Island	In 1996, Rhode Island enacted a law that specifically prohibits assisted suicide. If a person commits an assisted suicide, he or she can be charged with a criminal act or a civil penalty. R.I. Gen. Laws §11-60-1 to -5 (LEXIS through 2000 Sess.. Euthanasia is prohibited in Rhode Island under the general homicide laws.		
South Carolina	South Carolina has a law which specifically prohibits assisted suicide. If a person commits an assisted suicide, he or she can be charged with a criminal act or be assessed a penalty which is not considered a criminal act. S.C. Code Ann.§ 16-3-1090 (Law. Co- Op., LEXIS through 2000 Sess.). Euthanasia is prohibited in South Carolina under the general homicide laws.		
South Dakota	South Dakota has a law which specifically prohibits assisted suicide. The law was recently amended to allow an individual who commits an assisted suicide to be charged with a criminal act or be assessed a penalty which is not considered a criminal act. S.D. Codified Laws §22-16-37 (Michie, LEXIS through 2000 Legis. Sess.). Euthanasia is prohibited in South Dakota under the general homicide laws.		
Tennessee	In 1993, Tennessee enacted a law that specifically prohibits assisted suicide. If a person commits an assisted suicide, he or she can be charged with a criminal act or assessed a civil penalty. Tenn. Code Ann. §39-13-216 (LEXIS through 2000 Sess.). Euthanasia is prohibited in Tennessee under the general homicide laws.		
Texas	Texas has a law which specifically prohibits assisted suicide. Tex. Penal Code §22.08 (Vernon, LEXIS through 1999 Sess.). Euthanasia is prohibited in Texas under the general homicide laws.		
Utah	Utah has no law which specifically prohibits assisted suicide. Euthanasia is prohibited in Utah under the general homicide laws.		
Vermont	Vermont has no law which specifically prohibits assisted suicide. It is possible that assisted suicide is prohibited	Legislation to legalize physician-assisted suicide was defeated in 2002.	

	under the common law but there is no case law which indicates that assisted suicide would be considered a criminal act. Vt. Stat. Ann. tit. 1, §271 (LEXIS through 12/31/2001). Euthanasia is prohibited in Vermont under the general homicide laws.		
Virginia		In 1998, Virginia enacted a law that provides that a person who commits an assisted suicide can be assessed a civil penalty. Va. Code §8.01-662.1 (Michie, LEXIS through 2001 Sess.). Euthanasia is prohibited in Virginia under the general homicide laws.	
Washington	Washington has a law which specifically prohibits assisted suicide. Wash. Rev. Code. Ann. §9A.36.060 (West, LEXIS through Ch. 4, 2001 Sess.). Euthanasia is prohibited in Washington under the general homicide laws.		The U.S. Supreme Court upheld the Washington anti-assisted suicide law under the U.S. Constitution in *Washington v. Glucksberg*, 117 S. Ct. 2258 (1997).
West Virginia	West Virginia has no law which specifically prohibits assisted suicide. It is possible that assisted suicide is prohibited under the common law, however, there is no case law that clearly indicates that assisted suicide would be a criminal act. *State v. General Daniel Morgan Post No. 548*, 144 W. Va. 137, 107 S.E. 2d 353 (1959). Euthanasia is prohibited in West Virginia under the general homicide laws.		*State v. General Daniel Morgan Post No. 548*, 144 W. Va. 137, 107 S.E. 2d 353 (1959), indicates that assisted suicide may be prohibited by the common law.
Wisconsin	Wisconsin has a law which specifically prohibits assisted suicide. Wis. Stat. §940.12 (LEXIS through 1999-2000 legislation). Euthanasia is prohibited in Wisconsin under the general homicide laws.	Legislation has been introduced over the past ten years to legalize physician-assisted suicide in Wisconsin, but the state legislature has taken no action.	In 2001, a woman caregiver was found guilty under Wisconsin's law prohibiting assisted suicide for smothering her patient.
Wyoming			Wyoming has no law which specifically prohibits assisted suicide. Euthanasia is prohibited in Wyoming under the general homicide laws.

Source: Nightingale Alliance

Appendix B

A Twentieth Century Chronology of Voluntary Euthanasia and Physician-Assisted Suicide 1906 – 2008

1906 First euthanasia bill drafted in Ohio. It does not succeed.

1935 World's first euthanasia society is founded in London, England.

1938 The Euthanasia Society of America is founded by the Rev. Charles Potter in New York.

1954 Joseph Fletcher publishes Morals and Medicine, predicting the coming controversy over the right to die.

1957 Pope Pius XII issues Catholic doctrine distinguishing ordinary from extraordinary means for sustaining life.

1958 Oxford law professor Glanville Williams publishes The Sanctity of Life and the Criminal Law, proposing that voluntary euthanasia be allowed for competent, terminally ill patients.

1958 Lael Wertenbaker publishes Death of a Man describing how she helped her husband commit suicide. It is the first book of its genre.

1967 The first living will is written by attorney Louis Kutner and his arguments for it appear in the Indiana Law Journal.

1967 A right-to-die bill is introduced by Dr. Walter W. Sackett in Florida's legislature. It arouses extensive debate but is unsuccessful.

1968 Doctors at Harvard Medical School propose redefining death to include brain death as well as heart-lung death. Gradually this definition is accepted.

1969 Voluntary euthanasia bill introduced in the Idaho legislation. It fails.

1969 Elisabeth Kubler-Ross publishes On Death and Dying, opening discussion of the once-taboo subject of death.

1970 The Euthanasia Society (US) finishes distributing 60,000 living wills.

1973 American Hospital Association creates Patient Bill of Rights, which includes informed consent and the right to refuse treatment.

1973 Dr. Gertruida Postma, who gave her dying mother a lethal injection, receives light sentence in the Netherlands. The furore launches the euthanasia movement in that country (NVVE).

1974 The Euthanasia Society in New York renamed the Society for the Right to Die. The first hospice American hospice opens in New Haven, Conn.

1975 Deeply religious Van Dusens commit suicide. Henry P. Van Dusen, 77, and his wife, Elizabeth, 80, leaders of the Christian ecumenical movement, choose to die rather than suffer from disabling conditions. Their note reads, "We still feel this is the best way and the right way to go."

1975 Dutch Voluntary Euthanasia Society (NVVE) launches its Members' Aid Service to give advice to the dying. Receives 25 requests for aid in the first year.

1976 The New Jersey Supreme Court allows Karen Ann Quinlan's parents to disconnect the respirator that keeps her alive, saying it is affirming the choice Karen herself would have made. Quinlan case becomes a legal landmark. But she lives on for another eight years.

1976 California Natural Death Act is passed. The nation's first aid in dying statute gives legal standing to living wills and protects physicians from being sued for failing to treat incurable illnesses.

1976 Ten more U.S. states pass natural death laws.

1976 First international meeting of right-to-die groups. Six are represented in Tokyo.

1978 Doris Portwood publishes landmark book Commonsense Suicide: The Final Right. It argues that old people in poor health might justifiably kill themselves.

1978 Whose Life Is It Anyway?, a play about a young artist who becomes quadriplegic, is staged in London and on Broadway, raising disturbing questions about the right to die. A film version appears in 1982. Jean's Way is published in England by Derek Humphry, describing how he helped his terminally ill wife to die.

1979 Artist Jo Roman, dying of cancer, commits suicide at a much-publicized gathering of friends that is later broadcast on public television and reported by the New York Times.

1979 Two right-to-die organizations split. The Society for the Right to Die separates from Concern for Dying, a companion group that grew out of the Society's Euthanasia Education Council.

1980 Advice column Dear Abby publishes a letter from a reader agonizing over a dying loved one, generating 30,000 advance care directive requests at the Society for the Right to Die.

1980 Pope John Paul II issues Declaration in Euthanasia opposing mercy killing but permits the greater use of painkillers to ease pain and the right to refuse extraordinary means for sustaining life.

1980 Hemlock Society is founded in Santa Monica, California, by Derek Humphry. It advocates legal change and distributes how to die information. This launches the campaign for assisted dying in America. Hemlock's national membership will grow to 50,000 within a decade. Right to die societies also formed the same year in Germany and Canada.

1980 World Federation of Right to Die Societies is formed in Oxford, England. It comprises 27 groups from 18 nations.

1981 Hemlock publishes how-to suicide guide, Let Me Die Before I Wake, the first such book on open sale

1983 Famous author (Darkness at Noon etc) Arthur Koestler, terminally ill, commits suicide a year after publishing his reasons. His wife Cynthia, not dying, chooses to commit suicide with him.

1983 Elizabeth Bouvia, a quadriplegic suffering from cerebral palsy, sues a California hospital to let her die of self-starvation while receiving comfort care. She loses, and files an appeal.

1984 Advance care directives become recognized in 22 states and the District of Columbia.

1984 The Netherlands Supreme Court approves voluntary euthanasia under certain conditions.

1985 Karen Ann Quinlan dies.

1985 Betty Rollin publishes Last Wish, her account of helping her mother to die after a long losing battle with breast cancer. The book becomes a bestseller.

1986 Roswell Gilbert, 76, sentenced in Florida to 25 years without parole for shooting his terminally ill wife. Granted clemency five years later.

1986 Elizabeth Bouvia is granted the right to refuse force feeding by an appeals court. But she declines to take advantage of the permission and is still alive in l998.

1986 Americans Against Human Suffering is founded in California, launching a campaign for what will become the 1992 California Death with Dignity Act.

1987 The California State Bar Conference passes Resolution #3-4-87 to become the first public body to approve of physician aid in dying.

1988 Journal of the American Medical Association prints It's Over, Debbie, an unsigned article describing a resident doctor giving a lethal injection to a woman dying of ovarian cancer. The public prosecutor makes an intense, unsuccessful effort to identify the physician in the article.

1988 Unitarian Universalist Association of Congregations passes a national resolution favoring aid in dying for the terminally ill, becoming the first religious body to affirm a right to die.

1990 Washington Initiative (119) is filed, the first state voter referendum on the issue of voluntary euthanasia and physician-assisted suicide.

1990 American Medical Association adopts the formal position that with informed consent, a physician can withhold or withdraw treatment from a patient who is close to death, and may also discontinue life support of a patient in a permanent coma.

1990 Dr. Jack Kevorkian assists in the death of Janet Adkins, a middle-aged woman with Alzheimer's disease. Kevorkian subsequently flounts the Michigan legislature's attempts to stop him from assisting in additional suicides.

1990 Supreme Court decides the Cruzan case, its first aid in dying ruling. The decision recognizes that competent adults have a constitutionally protected liberty interest that includes a right to refuse medical treatment; the court also allows a state to impose procedural safeguards to protect its interests.

1990 Hemlock of Oregon introduces the Death With Dignity Act into the Oregon legislature, but it fails to get out of committee.

1990 Congress passes the Patient Self-Determination Act, requiring hospitals that receive federal funds to tell patients that they have a right to demand or refuse treatment. It takes effect the next year.

1991 Dr. Timothy Quill writes about "Diane" in the New England Journal of Medicine, describing his provision of lethal drugs to a leukemia patient who chose to die at home by her own hand rather than undergo therapy that offered a 25 percent chance of survival.
1991 Nationwide Gallup poll finds that 75 percent of Americans approve of living wills.

1991 Derek Humphry publishes Final Exit, a how-to book on self-deliverance. Within 18 months the book sells 540,000 copies and tops USA bestseller lists. It is translated into twelve other languages. Total sales exceed one million.

1991 Choice in Dying is formed by the merger of two aid in dying organizations, Concern for Dying and Society for the Right to Die. The new organization becomes known for defending patients' rights and promoting living wills, and will grow in five years to 150,000 members.

1991 Washington State voters reject Ballot Initiative 119, which would have legalized physician-aided suicide and aid in dying. The vote is 54-46 percent.

1992 Americans for Death with Dignity, formerly Americans Against Human Suffering, places the California Death with Dignity Act on the state ballot as Proposition 161.

1992 Health care becomes a major political issue as presidential candidates debate questions of access, rising costs, and the possible need for some form of rationing.

1992 California voters defeat Proposition 161, which would have allowed physicians to hasten death by actively administering or prescribing medications for self administration by suffering, terminally ill patients. The vote is 54-46 percent.

1993 Advance directive laws are achieved in 48 states, with passage imminent in the remaining two.

1993 Compassion in Dying is founded in Washington state to counsel the terminally ill and provide information about how to die without suffering and "with personal assistance, if necessary, to intentionally hasten death." The group sponsors suits challenging state laws against assisted suicide.

1993 President Clinton and Hillary Rodham Clinton publicly support advance directives and sign living wills, acting after the death of Hugh Rodham, Hillary's father.

1993 Oregon Right to Die, a political action committee, is founded to write and subsequently to pass the Oregon Death with Dignity Act.

1994 The Death with Dignity Education Center is founded in California as a national nonprofit organization that works to promote a comprehensive, humane, responsive system of care for terminally ill patients.

1994 More presidential living wills are revealed. After the deaths of former President Richard Nixon and former first lady Jacqueline Kennedy Onassis, it is reported that both had signed advance directives.

1994 The California Bar approves physician-assisted suicide. With an 85 percent majority and no active opposition, the Conference of Delegates says physicians should be allowed to prescribe medication to terminally ill, competent adults self-administration in order to hasten death.

1994 All states and the District of Columbia now recognize some type of advance directive procedure.

1994 Washington State's anti-suicide law is overturned. In Compassion v. Washington, a district court finds that a law outlawing assisted suicide violates the 14th Amendment. Judge Rothstein writes, "The court does not believe that a distinction can be drawn between refusing life-sustaining medical treatment and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult."

1994 In New York State, the lawsuit Quill et al v. Koppell is filed to challenge the New York law prohibiting assisted suicide. Quill loses, and files an appeal.

1994 Oregon voters approve Measure 16, a Death With Dignity Act ballot initiative that would permit terminally ill patients, under proper safeguards, to obtain a physician's prescription to end life in a humane and dignified manner. The vote is 51-49 percent.

1994 U.S. District Court Judge Hogan issues a temporary restraining order against Oregon's Measure 16, following that with an injunction barring the state from putting the law into effect.

1995 Oregon Death with Dignity Legal Defense and Education Center is founded. Its purpose is to defend Ballot Measure 16 legalizing physician-assisted suicide.

1995 Washington State's Compassion ruling is overturned by the Ninth Circuit Court of Appeals, reinstating the anti suicide law.

1995 U.S. District Judge Hogan rules that Oregon Measure 16, the Death with Dignity Act, is unconstitutional on grounds it violates the Equal Protection clause of the Constitution. His ruling is immediately appealed.

1995 Surveys find that doctors disregard most advance directives. Journal of the American Medical Association reports that physicians were unaware of the directives of three-quarters of all elderly patients admitted to a New York hospital; the California Medical Review reports that three-quarters of all advance directives were missing from Medicare records in that state.

1995 Oral arguments in the appeal of Quill v. Vacco contest the legality of New York's anti-suicide law before the Second Circuit Court of Appeals.

1995 Compassion case is reconsidered in Washington state by a Ninth Circuit Court of Appeals panel of eleven judges, the largest panel ever to hear a physician-assisted suicide case.

1996 The Northern Territory of Australia passes voluntary euthanasia law. Nine months later the Federal Parliament quashes it.

1996 The Ninth Circuit Court of Appeals reverses the Compassion finding in Washington state, holding that "a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors, violates the Due Process Clause." The ruling affects laws of nine western states. It is stayed pending appeal.

1996 A Michigan jury acquits Dr. Kevorkian of violating a state law banning assisted suicides.

1996 The Second Circuit Court of Appeals reverses the Quill finding, ruling that "The New York statutes criminalizing assisted suicide violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." The ruling affects laws in New York, Vermont and Connecticut. (On 17 April the court stays enforcement of its ruling for 30 days pending an appeal to the U.S. Supreme Court.)

1996 The U.S. Supreme Court announces that it will review both cases sponsored by Compassion in Dying, known now as Washington v. Glucksberg and Quill v. Vacco.

1997 Oral arguments set for the New York and Washington cases on physician assisted dying. The cases were heard in tandem on 8 January but not combined. A ruling is expected in June.

1997 ACLU attorney Robert Rivas files an amended complaint challenging the 128 year-old Florida law banning assisted suicide. Charles E. Hall, who has AIDS asks court permission for a doctor to assist his suicide. The court refuses.

1997 On 13 May the Oregon House of Representatives votes 32-26 to return Measure 16 to the voters in November for repeal (H.B. 2954). On 10 June the Senate votes 20-10 to pass H.B. 2954 and return Measure 16 to the voters for repeal. No such attempt to overturn the will of the voters has been tried in Oregon since 1908.

1997 On 26 June the U.S. Supreme Court reverses the decisions of the Ninth and Second Circuit Court of Appeals in Washington v. Glucksberg and Quill v. Vacco, upholding as constitutional state statutes which bar assisted suicide. However, the court also validated the concept of "double effect," openly acknowledging that death hastened by increased palliative measures does not constitute prohibited conduct so long as the intent is the relief of pain and suffering. The majority opinion ended with the pronouncement that "Throughout the nation, Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."

1997 Dutch Voluntary Euthanasia Society (NVVE) reports its membership now more than 90,000, of whom 900 made requests for help in dying to its Members' Aid Service.

1997 Britain's Parliament rejects by 234 votes to 89 the seventh attempt in 60 years to change the law on assisted suicide despite polls showing 82 percent of British people want reform.

1997 On 4 November the people of Oregon vote by a margin of 60-40 percent against Measure 51, which would have repealed the Oregon Death with Dignity Act, l994. The law officially takes effect (ORS 127.800-897) on 27 October l997 when court challenges disposed of.

1998 Dr. Kevorkian assists the suicide of his 92nd patient in eight years. His home state, Michigan, passes new law making such actions a crime. It took effect September, 1 1998, but Kevorkian carries on helping people to die -- 120 by November.

1998 Oregon Health Services Commission decides that payment for physician-assisted suicide can come from state funds under the Oregon Health Plan so that the poor will not be discriminated against.

1998 16 people die by making use of the Oregon Death With Dignity Act, receiving physician-assisted suicide in its first full year of implementation.

1998 Measure B on the Michigan ballot to legalize physician-assisted suicide defeated by 70 - 30%.

1999 Dr. Kevorkian sentenced to 10-25 years imprisonment for the 2nd degree murder of Thomas Youk after showing video of death by injection on national television.

1999 26 people die by physician-assisted suicide in the second full year of the Oregon PAS law.

2000 World Euthanasia Conference, Boston

2000 Citizens' Ballot Initiative in Maine to approve the lawfulness of Physician-Assisted Suicide was narrowly defeated 51-49 percent.

2001 Kevorkian's appeal decision reached after 2 years 7 months. Judges reject it.

2001 MS victim Diane Pretty asks UK court to allow her husband to help her commit suicide. The London High Court, the House of Lords, and the Court of Human Rights, in Strasbourg, all say no. She dies in hospice a few weeks later.

2002 Dutch law allowing voluntary euthanasia and physician-assisted suicide takes effect on 1 February. For 20 years previously it had been permitted under guidelines.

2002 Belgium passes similar law to the Dutch, allowing both voluntary euthanasia and physician-assisted suicide.

2003 US Attorney-General Ashcroft asks the 9th Circuit Court of Appeal to reverse the finding of a lower court judge that the Oregon Death With Dignity Act l994 does not contravene federal powers. 129 dying people have used this law over the last five years to obtain legal physician-assisted suicide. The losers of this appeal will almost certainly ask the US Supreme Court to rule.

Source: Euthanasia Research & Guidance Organization

Appendix C

Religious aspects of euthanasia

There are two main arguments offered by Christians, and those of other faiths, that advise against an individual seeking suicide, for whatever reason:

- Life is a gift from God, and that "*each individual [is] its steward.*" Thus, only God can start a life, and only God should be allowed to end one. An individual who commits suicide is committing sin.
- God does not send us any experience that we cannot handle. God supports people in suffering. To actively seek an end to one's life would represent a lack of trust in God's promise.

Of course, there is a significant and growing percentage of Agnostics, Atheists, Humanists, secularists, non-Christians and liberal Christians in North America who do not accept these theologically based arguments. They might argue:

- Each person has autonomy over their own life. Persons whose quality of life is nonexistent should have the right to decide to commit suicide, and to seek assistance if necessary.
- Sometimes a terminal illness is so painful that it causes life to be an unbearable burden; death can represent a relief of intolerable pain.

An active political question is whether individuals should be allowed to choose suicide, or whether they should be forced to follow the theological beliefs of the dominant religion. This point is similar to that raised in discussions on choice in abortion and compulsory prayer in public schools.

A number of religious organizations have issued statements on suicide and physician assisted suicide. Conservative faith groups tend to be most vocal in their opposition to suicide. Liberal denominations tend to be more in favor of individual choice:

- **Christian Reformed Church in North America:** In 1971 a Synod adopted a resolution which stated: "*that synod, mindful of the sixth commandment, condemn the wanton or arbitrary destruction of any human being at any state of its development from the point of conception to the point of death.*"

- **Evangelical Lutheran Church in America:** A 1992 statement on end-of-life matters from the *ELCA Church Council* supports passive euthanasia: "*Health care professionals are not required to use all available medical treatment in all circumstances. Medical treatment may be limited in some instances, and death allowed to occur.*" They oppose active euthanasia: "*...deliberately destroying life created in the image of God is contrary to our Christian conscience.*" However, they do acknowledge that physicians "*struggle to choose the lesser evil*" in some situations. e.g. when pain is so severe "*that life is indistinguishable from torture*." Surprisingly, even though physician-assisted suicide is a hotly debated topic, they do not comment on it. [5]

- **Islam:** The Qur'an states: "*Take not life which Allah made sacred otherwise than in the course of justice*" An essay on the web page of the *Islamic Center of Southern California* states that "*Since we did not create ourselves, we do not own our bodies...Attempting to kill oneself is a crime in Islam as well as a grave sin. The Qur'an says: 'Do not kill (or destroy) yourselves, for verily Allah has been to you most Merciful.'* (Quran 4:29)*...The concept of a life not worthy of living does not exist in Islam.*"

- **Lutheran Church - Missouri Synod:** In 1979, their *Commission on Theology and Church Relations* issued a report on euthanasia. It condemned euthanasia because it involves suicide and/or murder and is thus contrary to God's law. Suffering "*provides the opportunity for Christian witness and service.*"

- **Mennonites:** The Mennonite denomination is a decentralized faith group in which individual conferences make their own statements on social issues. The *Conference of* Menno*nites in Canada* issued a statement in 1995. They believe that pain, isolation and fear are the main factors that drive dying persons to consider suicide. They feel that the state should not facilitate suicide, but rather control physical and emotional pain and support the dying within a caring community setting.

- **Orthodox Christianity:** *The Greek Orthodox Archdiocese of America*, commenting on the case before the U.S. Supreme Court in 1996 commented: "*The Orthodox Church opposes murder, whether it be suicide, euthanasia or whatever, and regardless if it is cloaked in terms like 'death with dignity.' A person contemplating ending it all because of despondency instead should turn to God for strength and support. The Book of Job serves as a prime example of how someone overcomes extreme suffering by staying focused on God.*"

- **Orthodox Judaism:** The *Union of Orthodox Jewish Congregations of America* filed a brief in 1997-NOV to the Supreme Court. They supported laws which banned physician assisted suicide. Nathan Diament, director of their *Institute for Public Affairs* stated: "*This is an issue of critical constitutional and moral significance which Jewish tradition clearly speaks to. We believe that the recognition of a constitutionally recognized right to die for the terminally ill is a clear statement against the recognition and sanctity of human life...*"

- Roman Catholic Church: The *Catechism of the [Roman] Catholic Church* states:

"***2280***: *Everyone is responsible for his life before God who has given it to him. It is God Who remains the sovereign Master of life. We are obliged to accept life gratefully and preserve it for His honor and the salvation of our souls. We are stewards, not owners, of the life God has entrusted to us. It is not ours to dispose of.*"

- Salvation Army: "*The Salvation Army believes that people do not have the right to death by their own decision...Only God is sovereign over life and death...the grace of God can sustain through any ordeal or adversity.*"

- Unitarian Universalist: The *Unitarian-Universalist Association,* a liberal religious group, issued a statement in 1988 in support of euthanasia and choice in assisted suicide, but only if there are proper precautions in place to avoid abuse.

- Mainline and Liberal Christian denominations: Pro-choice statements have been made by the United Church of Christ, and the Methodist Church on the US West coast. The "*Episcopalian (Anglican) Unitarian, Methodist, Presbyterian and Quaker movements are amongst the most liberal, allowing at least individual decision making in cases of active euthanasia.*"

Source: Religious Tolerance

Appendix D

Oregon Death with Dignity Act

OARS
Reporting Requirements of the Oregon Death with Dignity Act

Please browse this page or download the rules (pdf) for printing. (*or read the OARS at*: http://arcweb.sos.state.or.us/

Definitions
333-009-0000.

For the purpose of OAR 333-009-0000 through 333-009-0030, the following definitions apply.

(1) "Act" means the "Oregon Death with Dignity Act" or Measure 16 as adopted by the voters on November 8, 1994.
(2) "Adult" means an individual who is 18 years of age or older.
(3) "Attending Physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
(4) "Capable" means that in the opinion of a court or in the opinion of the patient's attending physician or consulting physician, psychiatrist or psychologist, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.
(5)"Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
(6)"Counseling" means one or more consultations as necessary between a state licensed psychiatrist or psychologist and a patient for the purpose of determining that the patient is capable and not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.
(7) "Dispensing Record" means a copy of the pharmacy dispensing record form.
(8) "Department" means the Department of Human Services.
(9) "Health Care Facility" shall have the meaning given in ORS 442.015.
(10)"Health Care Provider" means a person licensed, certified or otherwise authorized or permitted by the law of this state to administer health care or dispense medication in the ordinary course of business or practice of a profession and includes a health care facility.
(11) "Patient" means a person who is under the care of a physician.
(12) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Medical Examiners for the State of Oregon.
(13) "Qualified patient" means a capable adult who is a resident of Oregon and has satisfied the requirements of this Act in order to obtain a prescription for medication to

end his or her life in a humane and dignified manner.
Stat. Auth.: ORS 127.800; 1999 Oregon Laws, Ch. 423
Stat. Implemented: ORS 127.800-127.995

Reporting
333-009-0010

(1) To comply with ORS 127.865(2), within seven calendar days of writing a prescription for medication to end the life of a qualified patient the attending physician shall send the following completed, signed and dated documentation by mail to the State Registrar, Center for Health Statistics, 800 NE Oregon Street, Suite 205, Portland OR 97232, or by facsimile to (971) 673-1201:
(a) The patient's completed written request for medication to end life, either using the "Written Request for Medication to End My Life in a Humane and Dignified Manner" form prescribed by the Department or in substantially the form described in ORS 127.897;

(b) One of the following reports prescribed by the Department:

(A) "Attending Physician's Compliance Form"; or

(B) "Attending Physician's Compliance Short Form" accompanied by a copy of the relevant portions of the patient's medical record documenting all actions required by the Act;

(c) "Consulting Physician's Compliance Form" prescribed by the Department; and

(d) "Psychiatric/Psychological Consultant's Compliance Form" prescribed by the Department, if an evaluation was performed.

(2) Within 10 calendar days of a patient's ingestion of lethal medication
obtained pursuant to the Act, or death from any other cause, whichever comes first, the attending physician shall complete the "Oregon Death with Dignity Act Attending Physician Interview" form prescribed by the Department.

(3) To comply with ORS 127.865 (1)(b), within 10 calendar days of dispensing medication pursuant to the Death with Dignity Act, the dispensing health care provider shall file a copy of the "Pharmacy Dispensing Record Form" prescribed by the Department with the State Registrar, Center for Health Statistics, 800 NE Oregon St., Suite 205, Portland, OR 97232; or by facsimile to (971) 673-1201. Information to be reported to the Department shall include:

(a) Patient's name and date of birth;

(b) Prescribing physician's name and phone number;

(c) Dispensing health care provider's name, address and phone number;

(d) Medication dispensed and quantity;

(e) Date the prescription was written; and

(f) Date the medication was dispensed.
Stat. Auth.: ORS 127.865
Stat. Implemented: ORS 127.800-127.995

Forms referenced are available from the agency at
http://egov.oregon.gov/DHS/ph/pas/pasforms.shtml

Record Review/Annual report
333-009-0020

(1) The Department shall annually review records maintained pursuant to this Act.
(2) The Department shall generate and make available to the public an annual statistical report of information collected under this Act.
Stat. Auth.: ORS 127.865
Stat. Implemented: ORS 127.800-127.995 and 432.060

Confidentiality/Liability
333-009-0030

(1) Except as otherwise required by law, all information collected pursuant to ORS 127.800 to 127.897 including, but not limited to, the identity of patients, physicians and other health care providers, and health care facilities shall not be a public record and may not be made available for inspection by the public.
(2) All information collected pursuant to ORS 127.800 to 127.897 and the annual statistical report referred to in 333-009-0020 (2) shall be considered a special morbidity and mortality study under ORS 432.060. Summary information released in statistical reports shall be aggregated to prevent identification of individuals, physicians, or health care facilities.
(3) Pursuant to ORS 432.060, providing morbidity and mortality information to the Department does not subject any physician, hospital, health care facility or other organization or person furnishing such information to an action for damages.
(4) Access to death certificate information shall be in accordance with OAR 333-011-0096 pursuant to ORS 432.121.
Stat. Auth.: ORS 127.865
Stat. Implemented: ORS 127.800-127.995, 432.060, and 432.121

Source: Oregon Secretary of State

Appendix E

SUPREME COURT OF THE UNITED STATES

No. 95-1858

DENNIS C. VACCO, ATTORNEY GENERAL OF NEW YORK, et al., PETITIONERS *v.* TIMOTHY E. QUILL et al.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

[June 26, 1997]

Chief Justice Rehnquist delivered the opinion of the Court.

In New York, as in most States, it is a crime to aid another to commit or attempt suicide, [n.1] but patients may refuse even lifesaving medical treatment. [n.2] The question presented by this case is whether New York's prohibition on assisting suicide therefore violates the Equal Protection Clause of the Fourteenth Amendment. We hold that it does not.

Petitioners are various New York public officials. Respondents Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman are physicians who practice in New York. They assert that although it would be "consistent with the standards of [their] medical practice[s]" to prescribe lethal medication for "mentally competent, terminally ill patients" who are suffering great pain and desire a doctor's help in taking their own lives, they are deterred from doing so by New York's ban on assisting suicide. App. 25-26. [n.3] Respondents, and three gravely ill patients who have since died, [n.4] sued the State's Attorney General in the United States District Court. They urged that because New York permits a competent person to refuse life sustaining medical treatment, and because the refusal of such treatment is "essentially the same thing" as physician assisted suicide, New York's assisted suicide ban violates the Equal Protection Clause. *Quill* v. *Koppell*, 870 F. Supp. 78, 84-85 (SDNY 1994).

The District Court disagreed: "[I]t is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death producing device." *Id.*, at 84. The court noted New York's "obvious legitimate interests in preserving life, and in protecting vulnerable persons," and concluded that "[u]nder the United States Constitution and the federal system it establishes, the resolution of this issue is left to the normal democratic processes within the State." *Id.*, at 84-85.

The Court of Appeals for the Second Circuit reversed. 80 F. 3d 716 (1996). The court determined that, despite the assisted suicide ban's apparent general applicability, "New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths," because "those in the final stages of terminal illness who are on life support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life sustaining equipment, are not allowed to hasten death by self administering prescribed drugs." *Id.*, at 727, 729. In the court's view, "[t]he ending of life by [the withdrawal of life support systems] is *nothing more nor less than assisted suicide*." *Id.*, at 729 (emphasis added) (citation omitted). The Court of Appeals then examined whether this supposed unequal treatment was rationally related to any legitimate state interests, [n.5] and concluded that "to the extent that [New York's statutes] prohibit a physician from prescribing medications to be self administered by a mentally competent, terminally ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." *Id.*, at 731. We granted certiorari, 518 U. S. ___ (1996), and now reverse.

The Equal Protection Clause commands that no State shall "deny to any person within its jurisdiction the equal protection of the laws." This provision creates no substantive rights. *San Antonio Independent School Dist.* v. *Rodriguez*, 411 U.S. 1, 33 (1973); *id.*, at 59 (Stewart, J., concurring). Instead, it embodies a general rule that States must treat like cases alike but may treat unlike cases accordingly. *Plyler* v. *Doe*, 457 U.S. 202, 216 (1982) (" `[T]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same' ") (quoting *Tigner* v. *Texas*, 310 U.S. 141, 147 (1940)). If a legislative classification or distinction "neither burdens a fundamental right nor targets a suspect class, we will uphold [it] so long as it bears a rational relation to some legitimate end." *Romer* v. *Evans*, 517 U. S. ___, ___ (slip op., at 10) (1996).

New York's statutes outlawing assisting suicide affect and address matters of profound significance to all New Yorkers alike. They neither infringe fundamental rights nor involve suspect classifications. *Washington* v. *Glucksberg*, *ante*, at 15-24; see 80 F. 3d, at 726; *San Antonio School Dist.*, 411 U. S., at 28 ("The system of alleged discrimination and the class it defines have none of the traditional indicia of suspectness"); *id.*, at 33-35 (courts must look to the Constitution, not the "importance" of the asserted right, when deciding whether an asserted right is "fundamental"). These laws are therefore entitled to a "strong presumption of validity." *Heller* v. *Doe*, 509 U.S. 312, 319 (1993).

On their faces, neither New York's ban on assisting suicide nor its statutes permitting patients to refuse medical treatment treat anyone differently than anyone else or draw any distinctions between persons. *Everyone*, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; *no one* is permitted to assist a suicide. Generally speaking, laws that apply evenhandedly to all "unquestionably comply" with the Equal Protection Clause. *New York City Transit Authority* v. *Beazer*, 440 U.S. 568, 587 (1979); see *Personnel Administrator of Mass.* v. *Feeney*, 442 U.S. 256, 271-273 (1979) ("[M]any [laws] affect certain groups unevenly, even though the law itself treats them no differently from all other members of the class described by the law").

The Court of Appeals, however, concluded that some terminally ill people--those who are on life support systems--are treated differently than those who are not, in that the former may "hasten death" by ending treatment, but the latter may not "hasten death" through physician assisted suicide. 80 F. 3d, at 729. This conclusion depends on the submission that ending or refusing lifesaving medical treatment "is nothing more nor less than assisted suicide." *Ibid*. Unlike the Court of Appeals, we think the distinction between assisting suicide and withdrawing life sustaining treatment, a distinction widely recognized and endorsed in the medical profession [n.6] and in our legal traditions, is both important and logical; it is certainly rational. See *Feeney*, *supra*, at 272 ("When the basic classification is rationally based, uneven effects upon particular groups within a class are ordinarily of no constitutional concern").

The distinction comports with fundamental legal principles of causation and intent. First, when a patient refuses life sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication. See, *e.g., People* v. *Kevorkian*, 447 Mich. 436, 470-472, 527 N. W. 2d 714, 728 (1994), cert. denied, 514 U.S. 1083 (1995); *Matter of Conroy*, 98 N. J. 321, 355, 486 A. 2d 1209, 1226 (1985) (when feeding tube is removed, death "result[s] . . . from [the patient's] underlying medical condition"); *In re Colyer*, 99 Wash. 2d 114, 123, 660 P. 2d 738, 743 (1983) ("[D]eath which occurs after the removal of life sustaining systems is from natural causes"); American Medical Association, Council on Ethical and Judicial Affairs, Physician Assisted Suicide, 10 Issues in Law & Medicine 91, 92 (1994) ("When a life sustaining treatment is declined, the patient dies primarily because of an underlying disease").

Furthermore, a physician who withdraws, or honors a patient's refusal to begin, life sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them." Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 368 (1996) (testimony of Dr. Leon R. Kass). The same is true when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or maybe, only to ease his patient's pain. A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead." *Id.*, at 367. Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not. See, *e.g.*, *Matter of Conroy, supra*, at 351, 486 A. 2d, at 1224 (patients who refuse life sustaining treatment "may not harbor a specific intent to die" and may instead "fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs"); *Superintendent of Belchertown*

State School v. *Saikewicz*, 373 Mass. 728, 743, n. 11, 370 N. E. 2d 417, 426, n. 11 (1977) ("[I]n refusing treatment the patient may not have the specific intent to die").

The law has long used actors' intent or purpose to distinguish between two acts that may have the same result. See, *e.g.*, *United States* v. *Bailey*, 444 U.S. 394, 403-406 (1980) ("[T]he . . . common law of homicide often distinguishes . . . between a person who knows that another person will be killed as the result of his conduct and a person who acts with the specific purpose of taking another's life"); *Morissette* v. *United States*, 342 U.S. 246, 250 (1952) (distinctions based on intent are "universal and persistent in mature systems of law"); M. Hale, 1 Pleas of the Crown 412 (1847) ("If A., with an intent to prevent gangrene beginning in his hand doth without any advice cut off his hand, by which he dies, he is not thereby *felo de se* for tho it was a voluntary act, yet it was not with an intent to kill himself"). Put differently, the law distinguishes actions taken "because of" a given end from actions taken "in spite of" their unintended but foreseen consequences. *Feeney*, 442 U. S., at 279; *Compassion in Dying* v. *Washington*, 79 F. 3d 790, 858 (CA9 1996) (Kleinfeld, J., dissenting) ("When General Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he was sending many American soldiers to certain death . . . . His purpose, though, was to . . . liberate Europe from the Nazis").

Given these general principles, it is not surprising that many courts, including New York courts, have carefully distinguished refusing life sustaining treatment from suicide. See, *e.g.*, *Fosmire* v. *Nicoleau*, 75 N. Y. 2d 218, 227, and n. 2, 551 N. E. 2d 77, 82, and n. 2 (1990) ("[M]erely declining medical . . . care is not considered a suicidal act"). **[n.7]** In fact, the first state court decision explicitly to authorize withdrawing lifesaving treatment noted the "real distinction between the self infliction of deadly harm and a self determination against artificial life support." *In re Quinlan*, 70 N. J. 10, 43, 52, and n. 9, 355 A. 2d 647, 665, 670, and n. 9, cert. denied *sub nom. Garger* v. *New Jersey*, 429 U.S. 922 (1976). And recently, the Michigan Supreme Court also rejected the argument that the distinction "between acts that artificially sustain life and acts that artificially curtail life" is merely a "distinction without constitutional significance--a meaningless exercise in semantic gymnastics," insisting that "the *Cruzan* majority disagreed and so do we." *Kevorkian*, 447 Mich., at 471, 527 N. W. 2d, at 728. **[n.8]**

Similarly, the overwhelming majority of state legislatures have drawn a clear line between assisting suicide and withdrawing or permitting the refusal of unwanted lifesaving medical treatment by prohibiting the former and permitting the latter. *Glucksberg*, *ante*, at 4-6, 11-15. And "nearly all states expressly disapprove of suicide and assisted suicide either in statutes dealing with durable powers of attorney in health care situations, or in `living will' statutes." *Kevorkian*, 447 Mich., at 478-479, and nn. 53-54, 527 N. W. 2d, at 731-732, and nn. 53-54. **[n.9]** Thus, even as the States move to protect and promote patients' dignity at the end of life, they remain opposed to physician assisted suicide.

New York is a case in point. The State enacted its current assisted suicide statutes in 1965. **[n.10]** Since then, New York has acted several times to protect patients' common law right to refuse treatment. Act of Aug. 7, 1987, ch. 818, §1, 1987 N. Y. Laws 3140 ("Do Not

Resuscitate Orders") (codified as amended at N. Y. Pub. Health Law §§2960-2979 (McKinney 1994 and Supp. 1997)); Act of July 22, 1990, ch. 752, §2, 1990 N. Y. Laws 3547 ("Health Care Agents and Proxies") (codified as amended at N. Y. Pub. Health Law §§2980-2994 (McKinney 1994 and Supp. 1997)). In so doing, however, the State has neither endorsed a general right to "hasten death" nor approved physician assisted suicide. Quite the opposite: The State has reaffirmed the line between "killing" and "letting die." See N. Y. Pub. Health Law §2989(3) (McKinney 1994) ("This article is not intended to permit or promote suicide, assisted suicide, or euthanasia"); New York State Task Force on Life and the Law, Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent 36-42 (July 1987); Do Not Resuscitate Orders: The Proposed Legislation and Report of the New York State Task Force on Life and the Law 15 (Apr. 1986). More recently, the New York State Task Force on Life and the Law studied assisted suicide and euthanasia and, in 1994, unanimously recommended against legalization. When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context vii (1994). In the Task Force's view, "allowing decisions to forego life sustaining treatment and allowing assisted suicide or euthanasia have radically different consequences and meanings for public policy." *Id.*, at 146.

This Court has also recognized, at least implicitly, the distinction between letting a patient die and making that patient die. In *Cruzan* v. *Director, Mo. Dept. of Health*, 497 U.S. 261, 278 (1990), we concluded that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions," and we assumed the existence of such a right for purposes of that case, *id.*, at 279. But our assumption of a right to refuse treatment was grounded not, as the Court of Appeals supposed, on the proposition that patients have a general and abstract "right to hasten death," 80 F. 3d, at 727-728, but on well established, traditional rights to bodily integrity and freedom from unwanted touching, *Cruzan*, 497 U. S., at 278-279; *id.*, at 287-288 (O'Connor, J., concurring). In fact, we observed that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Id.*, at 280. *Cruzan* therefore provides no support for the notion that refusing life sustaining medical treatment is "nothing more nor less than suicide."

For all these reasons, we disagree with respondents' claim that the distinction between refusing lifesaving medical treatment and assisted suicide is "arbitrary" and "irrational." Brief for Respondents 44. [n.11] Granted, in some cases, the line between the two may not be clear, but certainty is not required, even were it possible. [n.12] Logic and contemporary practice support New York's judgment that the two acts are different, and New York may therefore, consistent with the Constitution, treat them differently. By permitting everyone to refuse unwanted medical treatment while prohibiting anyone from assisting a suicide, New York law follows a longstanding and rational distinction.

New York's reasons for recognizing and acting on this distinction--including prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia--are discussed in greater detail in our opinion in *Glucksberg*, *ante*. These valid and important public interests easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end. [n.13]

The judgment of the Court of Appeals is reversed.

It is so ordered.

SUPREME COURT OF THE UNITED STATES

No. 96-110

WASHINGTON, et al., PETITIONERS *v.* HAROLD GLUCKSBERG et al.

on writ of certiorari to the united states court of appeals for the ninth circuit

[June 26, 1997]

Chief Justice Rehnquist delivered the opinion of the Court.

The question presented in this case is whether Washington's prohibition against "caus[ing]" or "aid[ing]" a suicide offends the FOURTEENTH AMENDMENT to the United States Constitution. We hold that it does not. It has always been a crime to assist a suicide in the State of Washington. In 1854, Washington's first Territorial Legislature outlawed "assisting another in the commission of self murder." [n.1] Today, Washington law provides: "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." Wash. Rev. Code 9A.36.060(1) (1994). "Promoting a suicide attempt" is a felony, punishable by up to five years' imprisonment and up to a $10,000 fine. §§9A.36.060(2) and 9A.20.021(1)(c). At the same time, Washington's Natural Death Act, enacted in 1979, states that the "withholding or withdrawal of life sustaining treatment" at a patient’s direction "shall not, for any purpose, constitute a suicide." Wash. Rev. Code §70.122.070(1). [n.2]

Petitioners in this case are the State of Washington and its Attorney General. Respondents Harold Glucksberg, M. D., Abigail Halperin, M. D., Thomas A. Preston, M. D., and Peter Shalit, M. D., are physicians who practice in Washington. These doctors occasionally treat terminally ill, suffering patients, and declare that they would assist these patients in ending their lives if not for Washington's assisted suicide ban. [n.3] In January 1994, respondents, along with three gravely ill, pseudonymous plaintiffs who have since died and Compassion in Dying, a nonprofit organization that counsels people considering physician assisted suicide, sued in the United States District Court, seeking a declaration that Wash Rev. Code 9A.36.060(1) (1994) is, on its face, unconstitutional. *Compassion in Dying* v. *Washington*, 850 F. Supp. 1454, 1459 (WD Wash. 1994). [n.4]

The plaintiffs asserted "the existence of a liberty interest protected by the Fourteenth Amendment which extends to a personal choice by a mentally competent, terminally ill adult to commit physician assisted suicide." *Id.*, at 1459. Relying primarily on *Planned Parenthood* v. *Casey*, 505 U.S. 833 (1992), and *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), the District Court agreed, 850 F. Supp., at 1459-1462, and concluded that Washington's assisted suicide ban is unconstitutional because it "places an undue burden on the exercise of [that] constitutionally protected liberty interest." *Id.*, at 1465. [n.5] The District Court also decided that the Washington statute violated the Equal Protection Clause's requirement that "`all persons similarly situated . . . be treated alike.'"

Id., at 1466 (quoting *Cleburne* v. *Cleburne Living Center, Inc.*, 473 U.S. 432, 439 (1985)).

A panel of the Court of Appeals for the Ninth Circuit reversed, emphasizing that "[i]n the two hundred and five years of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction." *Compassion in Dying* v. *Washington*, 49 F. 3d 586, 591 (1995). The Ninth Circuit reheard the case en banc, reversed the panel's decision, and affirmed the District Court. *Compassion in Dying* v. *Washington*, 79 F. 3d 790, 798 (1996). Like the District Court, the en banc Court of Appeals emphasized our *Casey* and *Cruzan* decisions. 79 F. 3d, at 813-816. The court also discussed what it described as "historical" and "current societal attitudes" toward suicide and assisted suicide, *id.*, at 806-812, and concluded that "the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death--that there is, in short, a constitutionally recognized `right to die.' " *Id.*, at 816. After "[w]eighing and then balancing" this interest against Washington's various interests, the court held that the State's assisted suicide ban was unconstitutional "as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians." *Id.*, at 836, 837. [n.6] The court did not reach the District Court's equal protection holding. *Id.*, at 838. [n.7] We granted certiorari, 519 U. S. ___ (1996), and now reverse.

I

We begin, as we do in all due process cases, by examining our Nation's history, legal traditions, and practices. See, *e.g.*, *Casey*, 505 U. S., at 849-850; *Cruzan*, 497 U. S., at 269-279; *Moore* v. *East Cleveland*, 431 U.S. 494, 503 (1977) (plurality opinion) (noting importance of "careful `respect for the teachings of history'"). In almost every State--indeed, in almost every western democracy--it is a crime to assist a suicide. [n.8] The States' assisted suicide bans are not innovations. Rather, they are longstanding expressions of the States' commitment to the protection and preservation of all human life. *Cruzan*, 497 U. S., at 280 ("[T]he States--indeed, all civilized nations--demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide"); see *Stanford* v. *Kentucky*, 492 U.S. 361, 373 (1989) ("[T]he primary and most reliable indication of [a national] consensus is . . . the pattern of enacted laws"). Indeed, opposition to and condemnation of suicide--and, therefore, of assisting suicide--are consistent and enduring themes of our philosophical, legal, and cultural heritages. See generally, Marzen, O'Dowd, Crone & Balch, Suicide: A Constitutional Right?, 24 Duquesne L. Rev. 1, 17-56 (1985) (hereinafter Marzen); New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context 77-82 (May 1994) (hereinafter New York Task Force).

More specifically, for over 700 years, the Anglo American common law tradition has punished or otherwise disapproved of both suicide and assisting suicide. [n.9] *Cruzan*, 497 U. S., at 294-295 (Scalia, J., concurring). In the 13th century, Henry de Bracton, one of the first legal treatise writers, observed that "[j]ust as a man may commit felony by slaying another so may he do so by slaying himself." 2 Bracton on Laws and Customs of England 423 (f.

150) (G. Woodbine ed., S. Thorne transl., 1968). The real and personal property of one who killed himself to avoid conviction and punishment for a crime were forfeit to the king; however, thought Bracton, "if a man slays himself in weariness of life or because he is unwilling to endure further bodily pain . . . [only] his movable goods [were] confiscated." *Id.*, at 423-424 (f. 150). Thus, "[t]he principle that suicide of a sane person, for whatever reason, was a punishable felony was . . . introduced into English common law." [n.10] Centuries later, Sir William Blackstone, whose Commentaries on the Laws of England not only provided a definitive summary of the common law but was also a primary legal authority for 18th and 19th century American lawyers, referred to suicide as "self murder" and "the pretended heroism, but real cowardice, of the Stoic philosophers, who destroyed themselves to avoid those ills which they had not the fortitude to endure . . . ." 4 W. Blackstone, Commentaries *189. Blackstone emphasized that "the law has . . . ranked [suicide] among the highest crimes," *ibid*, although, anticipating later developments, he conceded that the harsh and shameful punishments imposed for suicide "borde[r] a little upon severity." *Id.*, at *190.

For the most part, the early American colonies adopted the common law approach. For example, the legislators of the Providence Plantations, which would later become Rhode Island, declared, in 1647, that "[s]elf murder is by all agreed to be the most unnatural, and it is by this present Assembly declared, to be that, wherein he that doth it, kills himself out of a premeditated hatred against his own life or other humor: . . .his goods and chattels are the king's custom, but not his debts nor lands; but in case he be an infant, a lunatic, mad or distracted man, he forfeits nothing." The Earliest Acts and Laws of the Colony of Rhode Island and Providence Plantations 1647-1719, p. 19 (J. Cushing ed. 1977). Virginia also required ignominious burial for suicides, and their estates were forfeit to the crown. A. Scott, Criminal Law in Colonial Virginia 108, and n. 93, 198, and n. 15 (1930).

Over time, however, the American colonies abolished these harsh common law penalties. William Penn abandoned the criminal forfeiture sanction in Pennsylvania in 1701, and the other colonies (and later, the other States) eventually followed this example. *Cruzan,* 497 U. S., at 294 (Scalia, J., concurring). Zephaniah Swift, who would later become Chief Justice of Connecticut, wrote in 1796 that

"[t]here can be no act more contemptible, than to attempt to punish an offender for a crime, by exercising a mean act of revenge upon lifeless clay, that is insensible of the punishment. There can be no greater cruelty, than the inflicting [of] a punishment, as the forfeiture of goods, which must fall solely on the innocent offspring of the offender. . . . [Suicide] is so abhorrent to the feelings of mankind, and that strong love of life which is implanted in the human heart, that it cannot be so frequently committed, as to become dangerous to society. There can of course be no necessity of any punishment." 2 Z. Swift, A System of the Laws of the State of Connecticut 304 (1796).

This statement makes it clear, however, that the movement away from the common law's harsh sanctions did not represent an acceptance of suicide; rather, as Chief Justice Swift observed, this change reflected the growing consensus that it was unfair to punish the suicide's family for his wrongdoing. *Cruzan*, *supra*, at

294 (Scalia, J., concurring). Nonetheless, although States moved away from Blackstone's treatment of suicide, courts continued to condemn it as a grave public wrong. See, e.g., Bigelow v. Berkshire Life Ins. Co., 93 U.S. 284, 286 (1876) (suicide is "an act of criminal self destruction"); Von Holden v. Chapma n 66, 70-71, 450 N. Y. S. 2d 623, 626-627 (1982); Blackwood v. Jones, 111 Fla. 528, 532, 149 So. 600, 601 (1933) ("No sophistry is tolerated . . . which seek[s] to justify self destruction as commendable or even a matter of personal right").

That suicide remained a grievous, though nonfelonious, wrong is confirmed by the fact that colonial and early state legislatures and courts did not retreat from prohibiting assisting suicide. Swift, in his early 19th century treatise on the laws of Connecticut, stated that "[i]f one counsels another to commit suicide, and the other by reason of the advice kills himself, the advisor is guilty of murder as principal." 2 Z. Swift, A Digest of the Laws of the State of Connecticut 270 (1823). This was the well established common law view, see In re Joseph G., 34 Cal. 3d 429, 434-435, 667 P. 2d 1176, 1179 (1983); Commonwealth v. Mink, 123 Mass. 422, 428 (1877) ("`Now if the murder of one's self is felony, the accessory is equally guilty as if he had aided and abetted in the murder'") (quoting Chief Justice Parker's charge to the jury in Commonwealth v. Bowen, 13 Mass. 356 (1816)), as was the similar principle that the consent of a homicide victim is "wholly immaterial to the guilt of the person who cause[d] [his death]," 3 J. Stephen, A History of the Criminal Law of England 16 (1883); see 1 F. Wharton, Criminal Law §§451-452 (9th ed. 1885); Martin v. Commonwealth, 184 Va. 1009, 1018-1019, 37 S. E. 2d 43, 47 (1946) (" `The right to life and to personal security is not only sacred in the estimation of the common law, but it is inalienable' "). And the prohibitions against assisting suicide never contained exceptions for those who were near death. Rather, "[t]he life of those to whom life ha[d] become a burden--of those who [were] hopelessly diseased or fatally wounded--nay, even the lives of criminals condemned to death, [were] under the protection of law, equally as the lives of those who [were] in the full tide of life's enjoyment, and anxious to continue to live." Blackburn v. State, 23 Ohio St. 146, 163 (1872); see Bowen, supra, at 360 (prisoner who persuaded another to commit suicide could be tried for murder, even though victim was scheduled shortly to be executed).

The earliest American statute explicitly to outlaw assisting suicide was enacted in New York in 1828, Act of Dec. 10, 1828, ch. 20, §4, 1828 N. Y. Laws 19 (codified at 2 N. Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, §7, p. 661 (1829)), and many of the new States and Territories followed New York's example. Marzen 73-74. Between 1857 and 1865, a New York commission led by Dudley Field drafted a criminal code that prohibited "aiding" a suicide and, specifically, "furnish[ing] another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life." Id., at 76-77. By the time the Fourteenth Amendment was ratified, it was a crime in most States to assist a suicide. See Cruzan, supra, at 294-295 (Scalia, J., concurring). The Field Penal Code was adopted in the Dakota Territory in 1877, in New York in 1881, and its language served as a model for several other western States' statutes in the late 19th and early 20th centuries. Marzen 76-77, 205-206, 212-213. California, for example, codified its assisted suicide prohibition in 1874, using language similar to the Field Code's. [n.11] In this century, the Model Penal Code also prohibited "aiding" suicide, prompting many States to enact or revise their assisted suicide bans. [n.12] The Code's drafters observed that "the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim." American Law Institute, Model Penal Code §210.5, Comment 5, p. 100 (Official Draft and Revised Comments 1980).

Though deeply rooted, the States' assisted suicide bans have in recent years been reexamined and, generally, reaffirmed. Because of advances in medicine and technology, Americans today are increasingly likely to die in institutions, from chronic illnesses. President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life Sustaining Treatment 16-18 (1983). Public concern and democratic action are therefore sharply focused on how best to protect dignity and independence at the end of life, with the result that there have been many significant changes in state laws and in the attitudes these laws reflect. Many States, for example, now permit "living wills," surrogate health care decision making, and the withdrawal or refusal of life sustaining medical treatment. See Vacco v. Quill, post, at 9-11; 79 F. 3d, at 818-820; People v. Kevorkian, 447Mich. 436, 478-480, and nn. 53-56, 527 N. W. 2d 714, 731-732, and nn. 53-56 (1994). At the same time, however, voters and legislators continue for the most part to reaffirm their States' prohibitions on assisting suicide.

The Washington statute at issue in this case, Wash. Rev. Code §9A.36.060 (1994), was enacted in 1975 as part of a revision of that State's criminal code. Four years later, Washington passed its Natural Death Act, which specifically stated that the "withholding or withdrawal of life sustaining treatment . . . shall not, for any purpose, constitute a suicide" and that "[n]othing in this chapter shall be construed to condone, authorize, or approve mercy killing . . . ." Natural Death Act, 1979 Wash. Laws, ch. 112, §§8(1), p. 11 (codified at Wash. Rev. Code §§70.122.070(1), 70.122.100 (1994)). In 1991, Washington voters rejected a ballot initiative which, had it passed, would have permitted a form of physician assisted suicide. [n.13] Washington then added a provision to the Natural Death Act expressly excluding physician assisted suicide. 1992 Wash. Laws, ch. 98, §10; Wash. Rev. Code §70.122.100 (1994).

California voters rejected an assisted suicide initiative similar to Washington's in 1993. On the other hand, in 1994, voters in Oregon enacted, also through ballot initiative, that State's "Death With Dignity Act," which legalized physician assisted suicide for competent, terminally ill adults. [n.14] Since the Oregon vote, many proposals to legalize assisted suicide have been and continue to be introduced in the States' legislatures, but none has been enacted. [n.15] And just last year, Iowa and Rhode Island joined the overwhelming majority of States explicitly prohibiting assisted suicide. See Iowa Code Ann. §§707A.2, 707A.3 (Supp. 1997); R. I. Gen. Laws §§ 11-60-1, 11-60-3 (Supp. 1996). Also, on April 30, 1997, President Clinton signed the Federal Assisted Suicide Funding Restriction Act of 1997, which prohibits the use of federal funds in support of physician assisted suicide. Pub. L.

105-12, 111 Stat. 23 (codified at 42 U.S.C. § 14401 et seq). [n.16]

Thus, the States are currently engaged in serious, thoughtful examinations of physician assisted suicide and other similar issues. For example, New York State's Task Force on Life and the Law--an ongoing, blue ribbon commission composed of doctors, ethicists, lawyers, religious leaders, and interested laymen--was convened in 1984 and commissioned with "a broad mandate to recommend public policy on issues raised by medical advances." New York Task Force vii. Over the past decade, the Task Force has recommended laws relating to end of life decisions, surrogate pregnancy, and organ donation. Id., at 118-119. After studying physician assisted suicide, however, the Task Force unanimously concluded that "[l]egalizing assisted suicide and euthanasia would pose profound risks to many individuals who are ill and vulnerable. . . . [T]he potential dangers of this dramatic change in public policy would outweigh any benefit that might be achieved." Id., at 120.

Attitudes toward suicide itself have changed since Bracton, but our laws have consistently condemned, and continue to prohibit, assisting suicide. Despite changes in medical technology and notwithstanding an increased emphasis on the importance of end of life decision making, we have not retreated from this prohibition. Against this backdrop of history, tradition, and practice, we now turn to respondents' constitutional claim.

II

The Due Process Clause guarantees more than fair process, and the "liberty" it protects includes more than the absence of physical restraint. Collins v. Harker Heights, 503 U.S. 115, 125 (1992) (Due Process Clause "protects individual liberty against `certain government actions regardless of the fairness of the procedures used to implement them' ") (quoting Daniels v. Williams, 474 U.S. 327, 331 (1986)). The Clause also provides heightened protection against government interference with certain fundamental rights and liberty interests. Reno v. Flores, 507 U.S. 292, 301-302 (1993); Casey, 505 U. S., at 851. In a long line of cases, we have held that, in addition to the specific freedoms protected by the Bill of Rights, the "liberty" specially protected by the Due Process Clause includes the rights to marry, Loving v. Virginia, 388 U.S. 1 (1967); to have children, Skinner v. Oklahoma ex rel. Williamson, 316 U.S. 535 (1942); to direct the education and upbringing of one's children, Meyer v. Nebraska, 262 U.S. 390 (1923); Pierce v. Society of Sisters, 268 U.S. 510 (1925); to marital privacy, Griswold v. Connecticut, 381 U.S. 479 (1965); to use contraception, ibid; Eisenstadt v. Baird, 405 U.S. 438 (1972); to bodily integrity, Rochin v. California, Collins, 503 U. S., at 125. By extending constitutional protection to an asserted right or liberty interest, we, to a great extent, place the matter outside the arena of public debate and legislative action. We must therefore "exercise the utmost care whenever we are asked to break new ground in this field," ibid, lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of the members of this Court, Moore, 431 U. S., at 502 (plurality opinion).

Our established method of substantive due process analysis has two primary features: First, we have regularly observed that the Due Process Clause specially protects those fundamental rights and liberties which are, objectively, "deeply rooted in this Nation's history and tradition," id., at 503 (plurality opinion); Snyder v. Massachusetts, 291 U.S. 97, 105 (1934) ("so rooted in the traditions and conscience of our people as to be ranked as fundamental"), and "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if they were sacrificed," Palko v. Connecticut, 302 U.S. 319, 325, 326 (1937). Second, we have required in substantive due process cases a "careful description" of the asserted fundamental liberty interest. Flores, supra, at 302; Collins, supra, at 125; Cruzan, supra, at 277-278. Our Nation's history, legal traditions, and practices thus provide the crucial "guideposts for responsible decision making," Collins, supra, at 125, that direct and restrain our exposition of the Due Process Clause. As we stated recently in Flores, the Fourteenth Amendment "forbids the government to infringe . . . `fundamental' liberty interests at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest." 507 U. S., at 302.

Justice Souter, relying on Justice Harlan's dissenting opinion in Poe v. Ullman, would largely abandon this restrained methodology, and instead ask "whether [Washington's] statute sets up one of those `arbitrary impositions' or `purposeless restraints' at odds with the Due Process Clause of the Fourteenth Amendment," post, at 1 (quoting Poe, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting)). [n.17] In our view, however, the development of this Court's substantive due process jurisprudence, described briefly above, supra, at 15, has been a process whereby the outlines of the "liberty" specially protected by the Fourteenth Amendment--never fully clarified, to be sure, and perhaps not capable of being fully clarified--have at least been carefully refined by concrete examples involving fundamental rights found to be deeply rooted in our legal tradition. This approach tends to rein in the subjective elements that are necessarily present in due process judicial review. In addition, by establishing a threshold requirement--that a challenged state action implicate a fundamental right--before requiring more than a reasonable relation to a legitimate state interest to justify the action, it avoids the need for complex balancing of competing interests in every case.

Turning to the claim at issue here, the Court of Appeals stated that "[p]roperly analyzed, the first issue to be resolved is whether there is a liberty interest in determining the time and manner of one's death," 79 F. 3d, at 801, or, in other words, "[i]s there a right to die?," id., at 799. Similarly, respondents assert a "liberty to choose how to die" and a right to "control of one's final days," Brief for Respondents 7, and describe the asserted liberty as "the right to choose a humane, dignified death," id., at 15, and "the liberty to shape death," id., at 18. As noted above, we have a tradition of carefully formulating the interest at stake in substantive due process cases. For example, although Cruzan is often described as a "right to die" case, see 79 F. 3d, at 799; post, at 9 (Stevens, J., concurring in judgment) (Cruzan recognized "the more specific interest in making decisions about how to confront an imminent death"), we were, in fact, more precise: we assumed that the Constitution granted competent persons a "constitutionally protected right to refuse lifesaving hydration and nutrition." Cruzan, 497 U. S., at 279; id., at 287 (O'Connor, J., concurring) ("[A] liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions"). The Washington statute at issue in this case prohibits "aid[ing] another person to attempt suicide," Wash.

Rev. Code §9A.36.060(1) (1994), and, thus, the question before us is whether the "liberty" specially protected by the Due Process Clause includes a right to commit suicide which itself includes a right to assistance in doing so. [n.18]

We now inquire whether this asserted right has any place in our Nation's traditions. Here, as discussed above, supra, at 4-15, we are confronted with a consistent and almost universal tradition that has long rejected the asserted right, and continues explicitly to reject it today, even for terminally ill, mentally competent adults. To hold for respondents, we would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every State. See Jackman v. Rosenbaum Co., 260 U.S. 22, 31 (1922) ("If a thing has been practiced for two hundred years by common consent, it will need a strong case for the Fourteenth Amendment to affect it"); Flores, 507 U. S., at 303 (%The mere novelty of such a claim is reason enough to doubt that `substantive due process' sustains it").

Respondents contend, however, that the liberty interest they assert is consistent with this Court's substantive due process line of cases, if not with this Nation's history and practice. Pointing to Casey and Cruzan, respondents read our jurisprudence in this area as reflecting a general tradition of "self sovereignty," Brief of Respondents 12, and as teaching that the "liberty" protected by the Due Process Clause includes "basic and intimate exercises of personal autonomy," id., at 10; see Casey, 505 U. S., at 847 ("It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter"). According to respondents, our liberty jurisprudence, and the broad, individualistic principles it reflects, protects the "liberty of competent, terminally ill adults to make end of life decisions free of undue government interference." Brief for Respondents 10. The question presented in this case, however, is whether the protections of the Due Process Clause include a right to commit suicide with another's assistance. With this "careful description" of respondents' claim in mind, we turn to Casey and Cruzan.

In Cruzan, we considered whether Nancy Beth Cruzan, who had been severely injured in an automobile accident and was in a persistive vegetative state, "ha[d] a right under the United States Constitution which would require the hospital to withdraw life sustaining treatment" at her parents' request. Cruzan, 497 U. S., at 269. We began with the observation that "[a]t common law, even the touching of one person by another without consent and without legal justification was a battery." Ibid. We then discussed the related rule that "informed consent is generally required for medical treatment." Ibid. After reviewing a long line of relevant state cases, we concluded that "the common law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment." Id., at 277. Next, we reviewed our own cases on the subject, and stated that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." Id., at 278. Therefore, "for purposes of [that] case, we assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." Id., at 279; see id., at 287 (O'Connor, J., concurring). We concluded that, notwithstanding this right, the Constitution permitted Missouri to require clear and convincing evidence of an incompetent patient's wishes concerning the withdrawal of life sustaining treatment. Id., at 280-281.

Respondents contend that in Cruzan we "acknowledged that competent, dying persons have the right to direct the removal of life sustaining medical treatment and thus hasten death," Brief for Respondents 23, and that "the constitutional principle behind recognizing the patient's liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication," id., at 26. Similarly, the Court of Appeals concluded that "Cruzan, by recognizing a liberty interest that includes the refusal of artificial provision of life sustaining food and water, necessarily recognize[d] a liberty interest in hastening one's own death." 79 F. 3d, at 816.

The right assumed in Cruzan, however, was not simply deduced from abstract concepts of personal autonomy. Given the common law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment, our assumption was entirely consistent with this Nation's history and constitutional traditions. The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct. See Quill v. Vacco, post, at 5-13. In Cruzan itself, we recognized that most States outlawed assisted suicide--and even more do today--and we certainly gave no intimation that the right to refuse unwanted medical treatment could be somehow transmuted into a right to assistance in committing suicide. 497 U. S., at 280.

Respondents also rely on Casey. There, the Court's opinion concluded that "the essential holding of Roe v. Wade should be retained and once again reaffirmed." Casey, 505 U. S., at 846. We held, first, that a woman has a right, before her fetus is viable, to an abortion "without undue interference from the State"; second, that States may restrict post-viability abortions, so long as exceptions are made to protect a woman's life and health; and third, that the State has legitimate interests throughout a pregnancy in protecting the health of the woman and the life of the unborn child. Ibid. In reaching this conclusion, the opinion discussed in some detail this Court's substantive due process tradition of interpreting the Due Process Clause to protect certain fundamental rights and "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education," and noted that many of those rights and liberties "involv[e] the most intimate and personal choices a person may make in a lifetime." Id., at 851.

The Court of Appeals, like the District Court, found Casey "`highly instructive'" and "`almost prescriptive'" for determining "`what liberty interest may inhere in a terminally ill person's choice to commit suicide'":

%Like the decision of whether or not to have an abortion, the decision how and when to die is one of `the most intimate and personal choices a person may make in a lifetime,' a choice `central to personal dignity and autonomy.' " 79 F. 3d, at 813-814.

Similarly, respondents emphasize the statement in Casey that:

%At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." Casey, 505 U. S., at 851.

Brief for Respondents 12. By choosing this language, the Court's opinion in Casey described, in a general way and in light of our prior cases, those personal activities and decisions that this Court has identified as so deeply rooted in our history and traditions, or so fundamental to our concept of constitutionally ordered liberty, that they are protected by the Fourteenth Amendment. [n.19] The opinion moved from the recognition that liberty necessarily includes freedom of conscience and belief about ultimate considerations to the observation that "though the abortion decision may originate within the zone of conscience and belief, it is more than a philosophic exercise." Casey, 505 U. S., at 852 (emphasis added). That many of the rights and liberties protected by the Due Process Clause sound in personal autonomy does not warrant the sweeping conclusion that any and all important, intimate, and personal decisions are so protected, San Antonio Independent School Dist. v. Rodriguez, 411 U.S. 1, 33-35 (1973), and Casey did not suggest otherwise.

The history of the law's treatment of assisted suicide in this country has been and continues to be one of the rejection of nearly all efforts to permit it. That being the case, our decisions lead us to conclude that the asserted "right" to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. The Constitution also requires, however, that Washington's assisted suicide ban be rationally related to legitimate government interests. See Heller v. Doe, 509 U.S. 312, 319-320 (1993); Flores, 507 U. S., at 305. This requirement is unquestionably met here. As the court below recognized, 79 F. 3d, at 816-817, [n.20] Washington's assisted suicide ban implicates a number of state interests. [n.21] See 49 F. 3d, at 592-593; Brief for State of California et al. as Amici Curiae 26-29; Brief for United States as Amicus Curiae 16-27.

First, Washington has an "unqualified interest in the preservation of human life." Cruzan, 497 U. S., at 282. The State's prohibition on assisted suicide, like all homicide laws, both reflects and advances its commitment to this interest. See id., at 280; Model Penal Code §210.5, Comment 5, at 100 ("[T]he interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another"). [n.22] This interest is symbolic and aspirational as well as practical:

"While suicide is no longer prohibited or penalized, the ban against assisted suicide and euthanasia shores up the notion of limits in human relationships. It reflects the gravity with which we view the decision to take one's own life or the life of another, and our reluctance to encourage or promote these decisions." New York Task Force 131-132.

Respondents admit that "[t]he State has a real interest in preserving the lives of those who can still contribute to society and enjoy life." Brief for Respondents 35, n. 23. The Court of Appeals also recognized Washington's interest in protecting life, but held that the "weight" of this interest depends on the "medical condition and the wishes of the person whose life is at stake." 79 F. 3d, at 817. Washington, however, has rejected this sliding scale approach and, through its assisted suicide ban, insists that all persons' lives, from beginning to end, regardless of physical or mental condition, are under the full protection of the law. See United States v. Rutherford, 442 U.S. 544, 558 (1979) (". . . Congress could reasonably have determined to protect the terminally ill, no less than other patients, from the vast range of self styled panaceas that inventive minds can devise"). As we have previously affirmed, the States "may properly decline to make judgments about the `quality' of life that a particular individual may enjoy," Cruzan, 497 U. S., at282. This remains true, as Cruzan makes clear, even for those who are near death.

Relatedly, all admit that suicide is a serious public health problem, especially among persons in otherwise vulnerable groups. See Washington State Dept. of Health, Annual Summary of Vital Statistics 1991, pp. 29-30 (Oct. 1992) (suicide is a leading cause of death in Washington of those between the ages of 14 and 54); New York Task Force 10, 23-33 (suicide rate in the general population is about one percent, and suicide is especially prevalent among the young and the elderly). The State has an interest in preventing suicide, and in studying, identifying, and treating its causes. See 79 F. 3d, at 820; id., at 854 (Beezer, J., dissenting) ("The state recognizes suicide as a manifestation of medical and psychological anguish"); Marzen 107-146.

Those who attempt suicide--terminally ill or not--often suffer from depression or other mental disorders. See New York Task Force 13-22, 126-128 (more than 95% of those who commit suicide had a major psychiatric illness at the time of death; among the terminally ill, uncontrolled pain is a "risk factor" because it contributes to depression); Physician Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady to the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 10-11 (Comm. Print 1996); cf. Back, Wallace, Starks, & Pearlman, Physician Assisted Suicide and Euthanasia in Washington State, 275 JAMA 919, 924 (1996) ("[I]ntolerable physical symptoms are not the reason most patients request physician assisted suicide or euthanasia"). Research indicates, however, that many people who request physician assisted suicide withdraw that request if their depression and pain are treated. H. Hendin, Seduced by Death: Doctors, Patients and the Dutch Cure 24-25 (1997) (suicidal, terminally ill patients "usually respond well to treatment for depressive illness and pain medication and are then grateful to be alive"); New York Task Force 177-178. The New York Task Force, however, expressed its concern that, because depression is difficult to diagnose, physicians and medical professionals often fail to respond adequately to seriously ill patients' needs. Id., at 175. Thus, legal physician assisted suicide could make it more difficult for the State to protect depressed or mentally ill persons, or those who are suffering from untreated pain, from suicidal impulses.

The State also has an interest in protecting the integrity and ethics of the medical profession. In contrast to the Court of Appeals' conclusion that %the integrity of the medical profession would [not] be threatened in any way by [physician assisted suicide]," 79 F. 3d, at 827, the American Medical Association, like many other medical and physicians' groups, has concluded that "[p]hysician assisted suicide is fundamentally incompatible with the physician's role as healer." American Medical Association, Code of Ethics §2.211 (1994); see Council on Ethical and Judicial Affairs, Decisions Near the End of Life, 267 JAMA 2229, 2233 (1992) ("[T]he societal risks of involving physicians in medical interventions to cause patients' deaths is too great"); New York Task Force 103-109 (discussing physicians' views). And physician assisted suicide could, it is argued, undermine the trust that is essential to the doctor patient relationship by blurring the time honored line between healing and harming. Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 355-356 (1996) (testimony of Dr. Leon R. Kass) ("The patient's trust in the doctor's whole hearted devotion to his best interests will be hard to sustain").

Next, the State has an interest in protecting vulnerable groups--including the poor, the elderly, and disabled persons--from abuse, neglect, and mistakes. The Court of Appeals dismissed the State's concern that disadvantaged persons might be pressured into physician assisted suicide as "ludicrous on its face." 79 F. 3d, at 825. We have recognized, however, the real risk of subtle coercion and undue influence in end of life situations. Cruzan, 497 U. S., at 281. Similarly, the New York Task Force warned that legalizing physician assisted suicide would pose profound risks to many individuals who are ill and vulnerable. . . . The risk of harm is greatest for the many individuals in our society whose autonomy and well being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group." New York Task Force 120; see Compassion in Dying, 49 F. 3d, at 593 ("[A]n insidious bias against the handicapped--again coupled with a cost saving mentality--makes them especially in need of Washington's statutory protection"). If physician assisted suicide were permitted, many might resort to it to spare their families the substantial financial burden of end of life health care costs.

The State's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and "societal indifference." 49 F. 3d, at 592. The State's assisted suicide ban reflects and reinforces its policy that the lives of terminally ill, disabled, and elderly people must be no less valued than the lives of the young and healthy, and that a seriously disabled person's suicidal impulses should be interpreted and treated the same way as anyone else's. See New York Task Force 101-102; Physician Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady, at 9, 20 (discussing prejudice toward the disabled and the negative messages euthanasia and assisted suicide send to handicapped patients).

Finally, the State may fear that permitting assisted suicide will start it down the path to voluntary and perhaps even involuntary euthanasia. The Court of Appeals struck down Washington's assisted suicide ban only "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors." 79 F. 3d, at 838. Washington insists, however, that the impact of the court's decision will not and cannot be so limited. Brief for Petitioners 44-47. If suicide is protected as a matter of constitutional right, it is argued, "every man and woman in the United States must enjoy it." Compassion in Dying, 49 F. 3d, at 591; see Kevorkian, 447 Mich., at 470, n. 41, 527 N. W. 2d, at 727-728, n. 41. The Court of Appeals' decision, and its expansive reasoning, provide ample support for the State's concerns. The court noted, for example, that the "decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself," 79 F. 3d, at 832, n. 120; that "in some instances, the patient may be unable to self administer the drugs and . . . administration by the physician . . . may be the only way the patient may be able to receive them," id., at 831; and that not only physicians, but also family members and loved ones, will inevitably participate in assisting suicide. Id., at 838, n. 140. Thus, it turns out that what is couched as a limited right to "physician assisted suicide" is likely, in effect, a much broader license, which could prove extremely difficult to police and contain. [n.23] Washington's ban on assisting suicide prevents such erosion.

This concern is further supported by evidence about the practice of euthanasia in the Netherlands. The Dutch government's own study revealed that in 1990, there were 2,300 cases of voluntary euthanasia (defined as "the deliberate termination of another's life at his request"), 400 cases of assisted suicide, and more than 1,000 cases of euthanasia without an explicit request. In addition to these latter 1,000 cases, the study found an additional 4,941 cases where physicians administered lethal morphine overdoses without the patients' explicit consent. Physician Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady, at 12-13 (citing Dutch study). This study suggests that, despite the existence of various reporting procedures, euthanasia in the Netherlands has not been limited to competent, terminally ill adults who are enduring physical suffering, and that regulation of the practice may not have prevented abuses in cases involving vulnerable persons, including severely disabled neonates and elderly persons suffering from dementia. Id., at 16-21; see generally C. Gomez, Regulating Death: Euthanasia and the Case of the Netherlands (1991); H. Hendin, Seduced By Death: Doctors, Patients, and the Dutch Cure (1997). The New York Task Force, citing the Dutch experience, observed that "assisted suicide and euthanasia are closely linked," New York Task Force 145, and concluded that the "risk of . . . abuse is neither speculative nor distant," id., at 134. Washington, like most other States, reasonably ensures against this risk by banning, rather than regulating, assisting suicide. See United States v. 12 200-ft Reels of Super 8MM Film, 413 U.S. 123, 127 (1973) ("Each step, when taken, appear[s] a reasonable step in relation to that which preceded it, although the aggregate or end result is one that would never have been seriously considered in the first instance").

We need not weigh exactingly the relative strengths of these various interests. They are unquestionably important and legitimate, and Washington's ban on assisted suicide is at least reasonably related to their promotion and protection. We therefore hold that Wash. Rev. Code §9A.36.060(1) (1994) does not violate the Fourteenth Amendment, either on its face or "as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors." 79 F. 3d, at 838. [n.24]

* * *

morality, legality, and practicality of physician assisted suicide. Our holding permits this debate to continue, as it should in a democratic society. The decision of the en banc Court of Appeals is reversed, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

Notes

1 Act of Apr. 28, 1854, §17, 1854 Wash. Laws 78 ("Every person deliberately assisting another in the commission of self murder, shall be deemed guilty of manslaughter"); see also Act of Dec. 2, 1869, §17, 1869 Wash. Laws 201; Act of Nov. 10, 1873, §19, 1873 Wash. Laws 184; Criminal Code, ch. 249, §§135-136, 1909 Wash. Laws, 11th sess., 929.

2 Under Washington's Natural Death Act, "adult persons have the fundamental right to control the decisions relating to the rendering of their own health care, including the decision to have life sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition." Wash. Rev. Code §70.122.010 (1994). In Washington, "[a]ny adult person may execute a directive directing the withholding or withdrawal of life sustaining treatment in a terminal condition or permanent unconscious condition," §70.122.030, and a physician who, in accordance with such a directive, participates in the withholding or withdrawal of life sustaining treatment is immune from civil, criminal, or professional liability. §70.122.051.

3 Glucksberg Declaration, App. 35; Halperin Declaration, id., at 49-50; Preston Declaration, id., at 55-56; Shalit Declaration, id., at 73-74.

4 John Doe, Jane Roe, and James Poe, plaintiffs in the District Court, were then in the terminal phases of serious and painful illnesses. They declared that they were mentally competent and desired assistance in ending their lives. Declaration of Jane Roe, id., at 23-25; Declaration of John Doe, id., at 27-28; Declaration of James Poe, id., at 30-31; Compassion in Dying, 850 F. Supp., at 1456-1457.

5 The District Court determined that Casey's "undue burden" standard, 505 U. S., at 874 (joint opinion), not the standard from United States v. Salerno, 481 U.S. 739, 745 (1987) (requiring a showing that "no set of circumstances exists under which the [law] would be valid"), governed the plaintiffs' facial challenge to the assisted suicide ban. 850 F. Supp., at 1462-1464.

6 Although, as Justice Stevens observes, post, at 2-3 (opinion concurring in judgment), "[the court's] analysis and eventual holding that the statute was unconstitutional was not limited to a particular set of plaintiffs before it," the court did note that "[d]eclaring a statute unconstitutional as applied to members of a group is atypical but not uncommon." 79 F. 3d, at 798, n. 9, and emphasized that it was "not deciding the facial validity of [the Washington

statute]," id., at 797-798, and nn. 8-9. It is therefore the court's holding that Washington's physician assisted suicide statute is unconstitutional as applied to the "class of terminally ill, mentally competent patients," post, at 14 (Stevens, J., concurring in judgment), that is before us today.

7 The Court of Appeals did note, however, that "the equal protection argument relied on by [the District Court] is not insubstantial," 79 F. 3d., at 838, n. 139, and sharply criticized the opinion in a separate case then pending before the Ninth Circuit, Lee v. Oregon, 891 F. Supp. 1429 (Ore. 1995) (Oregon's Death With Dignity Act, which permits physician assisted suicide, violates the Equal Protection Clause because it does not provide adequate safeguards against abuse), vacated, Lee v. Oregon, 107 F. 3d 1382 (CA9 1997) (concluding that plaintiffs lacked Article III standing). Lee, of course, is not before us, any more than it was before the Court of Appeals below, and we offer no opinion as to the validity of the Lee courts' reasoning. In Vacco v. Quill, post, however, decided today, we hold that New York's assisted suicide ban does not violate the Equal Protection Clause.

8 See Compassion in Dying v. Washington, 79 F. 3d 790, 847, and nn. 10-13 (CA9 1996) (Beezer, J., dissenting) ("In total, forty four states, the District of Columbia and two territories prohibit or condemn assisted suicide") (citing statutes and cases); Rodriguez v. British Columbia (Attorney General), 107 D. L. R. (4th) 342, 404 (Can. 1993) ("[A] blanket prohibition on assisted suicide . . . is the norm among western democracies") (discussing assisted suicide provisions in Austria, Spain, Italy, the United Kingdom, the Netherlands, Denmark, Switzerland, and France). Since the Ninth Circuit's decision, Louisiana, Rhode Island, and Iowa have enacted statutory assisted suicide bans. La. Rev. Stat. Ann. §14:32.12 (Supp. 1997); R. I. Gen. Laws §§11-60-1, 11-60-3 (Supp. 1996); Iowa Code Ann. §§707A.2, 707A.3 (Supp. 1997). For a detailed history of the States' statutes, see Marzen, O'Dowd, Crone & Balch, Suicide: A Constitutional Right?, 24 Duquesne L. Rev. 1, 148-242 (1985) (Appendix) (hereinafter Marzen).

9 The common law is thought to have emerged through the expansion of pre-Norman institutions sometime in the 12th century. J. Baker, An Introduction to English Legal History 11 (2d ed. 1979). England adopted the ecclesiastical prohibition on suicide five centuries earlier, in the year 673 at the Council of Hereford, and this prohibition was reaffirmed by King Edgar in 967. See G. Williams, The Sanctity of Life and the Criminal Law 257 (1957).

10 Marzen 59. Other late medieval treatise writers followed and restated Bracton; one observed that "man slaughter" may be "[o]f [one]self; as in case, when people hang themselves or hurt themselves, or otherwise kill themselves of their own felony" or "[o]f others; as by beating, famine, or other punishment; in like cases, all are man slayers." A. Horne, The Mirrour of Justices, ch. 1, §9, pp. 41-42 (W. Robinson ed. 1903). By the mid 16th century, the Court at Common Bench could observe that "[suicide] is an Offence against Nature, against God, and against the King. . . . [T]o destroy one's self is contrary to Nature, and a Thing most horrible." Hales v. Petit, 1 Plowd. Com. 253, 261, 75 Eng. Rep. 387, 400 (1561-1562).

In 1644, Sir Edward Coke published his Third Institute, a lodestar for later common lawyers. See T. Plucknett, A Concise History of the Common Law 281-284 (5th ed. 1956). Coke regarded suicide as a category of murder, and agreed with Bracton that the goods and chattels--but not, for Coke, the lands--of a sane suicide were forfeit. 3 E. Coke, Institutes *54. William Hawkins, in his 1716 Treatise of the Pleas of the Crown, followed Coke, observing that "our laws have always had . . . an abhorrence of this crime." 1 W. Hawkins, Pleas of the Crown, ch. 27, §4, p. 164 (T. Leach ed. 1795).

11 In 1850, the California legislature adopted the English common law, under which assisting suicide was, of course, a crime. Act of Apr. 13, 1850, ch. 95, 1850 Cal. Stats. 219. The provision adopted in 1874provided that "[e]very person who deliberately aids or advises, or encourages another to commit suicide, is guilty of a felony." Act of Mar. 30, 1874, ch. 614, §13, 400, 255 (codified at Cal. Penal Code §400 (T. Hittel ed. 1876)).

12 %A person who purposely aids or solicits another to commit suicide is guilty of a felony in the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor." American Law Institute, Model Penal Code §210.5(2) (Official Draft and Revised Comments 1980).

13 Initiative 119 would have amended Washington's Natural Death Act, Wash. Rev. Code §70.122.010 et seq. (1994), to permit "aid in dying", defined as "aid in the form of a medical service provided in person by a physician that will end the life of a conscious and mentally competent qualified patient in a dignified, painless and humane manner, when requested voluntarily by the patient through a written directive in accordance with this chapter at the time the medical service is to be provided." App. H to Pet. for Cert. 3-4.

14 Ore. Rev. Stat. §§127.800 et seq. (1996); Lee v. Oregon, 891 F. Supp.1429 (Ore. 1995) (Oregon Act does not provide sufficient safeguards for terminally ill persons and therefore violates the Equal Protection Clause), vacated, Lee v. Oregon, 107 F. 3d 1382 (CA9 1997).

15 See, e.g., Alaska H. B. 371 (1996); Ariz. S. B. 1007 (1996); Cal. A. B. 1080, A. B. 1310 (1995); Colo. H. B. 1185 (1996); Colo. H. B. 1308 (1995); Conn. H. B. 6298 (1995); Ill. H. B. 691, S. B. 948 (1997); Me. H. P. 663 (1997); Me. H. P. 552 (1995); Md. H. B. 474 (1996); Md. H. B. 933 (1995); Mass. H. B. 3173 (1995); Mich. H. B. 6205 (1996); Mich. S. B. 556 (1996); Mich. H. B. 4134 (1995); Miss. H. B. 1023 (1996); N. H. H. B. 339 (1995); N. M. S. B. 446 (1995); N. Y. S. B. 5024 (1995); N. Y. A. B. 6333 (1995); Neb. L. B. 406 (1997); Neb. L. B. 1259 (1996); R. I. S. 2985 (1996); Vt. H. B. 109 (1997); Vt. H. B. 335 (1995); Wash. S. B. 5596 (1995); Wis. A. B. 174, S. B. 90 (1995); Senate of Canada, Of Life and Death, Report of the Special Senate Committee on Euthanasia and Assisted Suicide A--156 (June 1995) (describing unsuccessful proposals, between 1991-1994, to legalize assisted suicide).

16 Other countries are embroiled in similar debates: The Supreme Court of Canada recently rejected a claim that the Canadian Charter of Rights and Freedoms establishes a

fundamental right to assisted suicide, Rodriguez v. British Columbia (Attorney General), 107 D. L. R. (4th) 342 (1993); the British House of Lords Select Committee on Medical Ethics refused to recommend any change in Great Britain's assisted suicide prohibition, House of Lords, Session 1993-94 Report of the Select Committee on Medical Ethics, 12 Issues in Law & Med. 193, 202 (1996) ("We identify no circumstances in which assisted suicide should be permitted"); New Zealand's Parliament rejected a proposed "Death With Dignity Bill" that would have legalized physician assisted suicide in August 1995, Graeme, MPs Throw out Euthanasia Bill, The Dominion (Wellington), Aug. 17, 1995, p. 1; and the Northern Territory of Australia legalized assisted suicide and voluntary euthanasia in 1995. See Shenon, Australian Doctors Get Right to Assist Suicide, N.Y. Times, July 28, 1995, p. A8. As of February 1997, three persons had ended their lives with physician assistance in the Northern Territory. Mydans, Assisted Suicide: Australia Faces a Grim Reality, N. Y. Times, Febr. 2, 1997, p. A3. On March 24, 1997, however, the Australian Senate voted to overturn the Northern Territory's law. Thornhill, Australia Repeals Euthanasia Law, Washington Post, March 25, 1997, p. A14; see Euthanasia Laws Act 1997, No. 17, 1997 (Austl.). On the other hand, on May 20, 1997, Colombia's Constitutional Court legalized voluntary euthanasia for terminally ill people. Sentencia No. C 239/97 (Corte Constitucional, Mayo 20, 1997); see Colombia's Top Court Legalizes Euthanasia, Orlando Sentinel, May 22, 1997, p. A18.

17 In Justice Souter's opinion, Justice Harlan's Poe dissent supplies the "modern justification" for substantive due process review. Post, at 5, and n. 2 (Souter, J., concurring in judgment). But although Justice Harlan's opinion has often been cited in due process cases, we have never abandoned our fundamental rights based analytical method. Just four Terms ago, six of the Justices now sitting joined the Court's opinion in Reno v. Flores, 507 U.S. 292, 301-305 (1993); Poe was not even cited. And in Cruzan, neither the Court's nor the concurring opinions relied on Poe; rather, we concluded that the right to refuse unwanted medical treatment was so rooted in our history, tradition, and practice as to require special protection under the Fourteenth Amendment. Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261, 278-279 (1990); id., at 287-288 (O'Connor, J., concurring). True, the Court relied on Justice Harlan's dissent in Casey, 505 U. S., at 848-850, but, as Flores demonstrates, we did not in so doing jettison our established approach. Indeed, to read such a radical move into the Court's opinion in Casey would seem to fly in the face of that opinion's emphasis on stare decisis. 505 U. S., at 854-869.

18 See, e.g., Quill v. Vacco, 80 F. 3d 716, 724 (CA2 1996) ("right to assisted suicide finds no cognizable basis in the Constitution's language or design"); Compassion in Dying v. Washington, 49 F. 3d 586, 591 (CA9 1995) (referring to alleged "right to suicide," "right to assistance in suicide," and "right to aid in killing oneself"); People v. Kevorkian, 447 Mich. 436, 476, n. 47, 527 N. W. 2d 714, 730, n. 47 (1994) ("[T]he question that we must decide is whether the [C]onstitution encompasses a right to commit suicide and, if so, whether it includes a right to assistance").

19 See Moore v. East Cleveland, 431 U.S. 494, 503 (1977) ("[T]he Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this

Nation's history and tradition") (emphasis added); Griswold v. Connecticut, 381 U.S. 479, 485-486 (1965) (intrusions into the "sacred precincts of marital bedrooms" offend rights "older than the Bill of Rights"); id., at 495-496 (Goldberg, J., concurring) (the law in question "disrupt[ed] the traditional relation of the family--a relation as old and as fundamental as our entire civilization"); Loving v. Virginia, 388 U.S. 1, 12 (1967) ("The freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness"); Turner v. Safley, 482 U.S. 78, 95 (1987) ("[T]he decision to marry is a fundamental right"); Roe v . Wade, 410 U.S. 113, 140 (1973) (stating that at the Founding and throughout the 19th century, "a woman enjoyed a substantially broader right to terminate a pregnancy"); Skinner v. Oklahoma ex rel. Williamson, 316 U.S. 535, 541 (1942) ("Marriage and procreation are fundamental"); Pierc e Nebraska, 262 U.S. 390, 399 (1923) (liberty includes "those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men").

20 The court identified and discussed six state interests: (1) preserving life; (2) preventing suicide; (3) avoiding the involvement of third parties and use of arbitrary, unfair, or undue influence; (4) protecting family members and loved ones; (5) protecting the integrity of the medical profession; and (6) avoiding future movement toward euthanasia and other abuses. 79 F. 3d, at 816-832.

21 Respondents also admit the existence of these interests, Brief for Respondents 28-39, but contend that Washington could better promote and protect them through regulation, rather than prohibition, of physician assisted suicide. Our inquiry, however, is limited to the question whether the State's prohibition is rationally related to legitimate state interests.

22 The States express this commitment by other means as well: %[N]early all states expressly disapprove of suicide and assisted suicide either in statutes dealing with durable powers of attorney in health care situations, or in `living will' statutes. In addition, all states provide for the involuntary commitment of persons who may harm themselves as the result of mental illness, and a number of states allow the use of nondeadly force to thwart suicide attempts." People v. Kevorkian, 447 Mich., at 478-479, and nn. 53-56, 527 N. W. 2d, at 731-732, and nn. 53-56.

23 Justice Souter concludes that "[t]he case for the slippery slope is fairly made out here, not because recognizing one due process right would leave a court with no principled basis to avoid recognizing another, but because there is a plausible case that the right claimed would not be readily containable by reference to facts about the mind that are matters of difficult judgment, or by gatekeepers who are subject to temptation, noble or not." Post, at 36-37 (opinion concurring in judgment). We agree that the case for a slippery slope has been made out, but--bearing in mind Justice Cardozo's observation of "[t]he tendency of a principle to expand itself to the limit of its logic," The Nature of the Judicial Process 51 (1932)--we also recognize the reasonableness of the widely expressed skepticism about the lack of a principled basis for confining the right. See Brief for United States as Amicus Curiae 26 ("Once a legislature abandons a categorical prohibition against physician assisted suicide, there is no obvious stopping point"); Brief for Not Dead Yet et al. as Amici Curiae

21-29; Brief for Bioethics Professors as Amici Curiae 23-26; Report of the Council on Ethical and Judicial Affairs, App. 133, 140 ("[I]f assisted suicide is permitted, then there is a strong argument for allowing euthanasia"); New York Task Force 132; Kamisar, The "Right to Die": On Drawing (and Erasing) Lines, 35 Duquesne L. Rev. 481 (1996); Kamisar, Against Assisted Suicide--Even in a Very Limited Form, 72 U. Det. Mercy L. Rev. 735 (1995).

24 Justice Stevens states that "the Court does conceive of respondents' claim as a facial challenge--addressing not the application of the statute to a particular set of plaintiffs before it, but the constitutionality of the statute's categorical prohibition . . . ." Post, at 4 (opinion concurring in judgment). We emphasize that we today reject the Court of Appeals' specific holding that the statute is unconstitutional "as applied" to a particular class. See n. 6, supra. Justice Stevens agrees with this holding, see post, at 14, but would not "foreclose the possibility that an individual plaintiff seeking to hasten her death, or a doctor whose assistance was sought, could prevail in a more particularized challenge," ibid. Our opinion does not absolutely foreclose such a claim. However, given our holding that the Due Process Clause of the Fourteenth Amendment does not provide heightened protection to the asserted liberty interest in ending one's life with a physician's assistance, such a claim would have to be quite different from the ones advanced by respondents here.

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Appendix F

The California Death With Dignity Act

California Civil Code, Title 10.5

SEC. 1. Title 10.5 (commencing with Section 2525 added to Division 3 of part 4 of the Civil Code, to read:

2525. TITLE

This title shall be known and may be cited as the Death With Dignity Act.

2525.1. DECLARATION OF PURPOSE.

The people of California declare:

Current state laws do not adequately protect the rights of terminally ill patients. The purpose of this Act is to provide mentally competent terminally ill adults the legal right to voluntarily request and receive physician aid-in-dying. This Act protects physicians who voluntarily comply with the request and provides strong safeguards against abuse. The Act requires the signing of a witnessed revocable Directive in advance and then requires a terminally ill patient to communicate his or her request directly to the treating physician.

Self-determination is the most basic of freedoms. The right to choose to eliminate pain and suffering, and to die with dignity at the time and place of our own choosing when we are terminally ill is an integral part of our right to control our own destinies. That right is hereby established in law, but limited to ensure that the rights of others are not affected. The right should include the ability to make a conscious and informed choice to enlist the assistance of the medical profession in making death as painless, humane, and dignified as possible.

Modern medical technology has made possible the artificial prolongation of human life beyond natural limits. This prolongation of life for persons with terminal conditions may cause loss of patient dignity and unnecessary pain and suffering, for both the patient and the family, while providing nothing medically necessary or beneficial to the patient.

In recognition of the dignity which patients have a right to expect, the State of California recognizes the right of mentally competent terminally ill adults to make a voluntary revocable written Directive instructing their physician to administer aid-in-dying to end their life in a painless, humane and dignified manner.

The Act is voluntary. Accordingly, no one shall be required to take advantage of this legal right or to participate if they are religiously, morally or ethically opposed.

2525.2 DEFINITIONS

The following definitions shall govern the construction of this title:

(a) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(b) "Directive" means a revocable written document voluntarily executed by the declarant in accordance with the requirements of Section 2525.3 in substantially the form set forth in Section 2525.24.

(c) "Declarant" means a person who executes a Directive, in accordance with this title.

(d) "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, including nourishment and hydration which, when applied to a qualified patient, would serve only to prolong artificially the moment of death. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain or reverse any condition.

(e) "Physician" means a physician and surgeon licensed by the Medical Board of California.

(f) "Health care provider" and "Health care professional" mean a person or facility or employee of a health care facility licensed, certified, or otherwise authorized by the law of this state to administer health care in the ordinary course of business or practice of a profession.

(g) "Community care facility" means a community care facility as defined in Section 1502 of the Health and Safety Code.

(h) "Qualified patient" means a mentally competent adult patient who has voluntarily executed a currently valid revocable Directive as defined in this section, who has been diagnosed and certified in writing by two physicians to be afflicted with a terminal condition, and who has expressed an enduring request for aid-in-dying. One of said physicians shall be the attending physician as defined in subsection (a). Both physicians shall have personally examined the patient.

(i) "Enduring request" means a request for aid-in-dying, expressed on more than one occasion.

(j) "Terminal condition" means an incurable or irreversible condition which will, in the opinion of two certifying physicians exercising reasonable medical judgment, result in death within six months or less. One of said physicians shall be the attending physician as defined in subsection (a).

(k) "Aid-in-dying" means a medical procedure that will terminate the life of the qualified patient in a painless, humane and dignified manner whether administered by the physician at the patient's choice or direction or whether the physician provides means to the patient for self-administration.

2525.3 WITNESSED DIRECTIVE

A mentally competent adult individual may at any time voluntarily execute a revocable Directive governing the administration of aid-in-dying. The Directive shall be signed by the declarant and witnessed by two adults who at the time of witnessing, meet the following requirements:

(a) Are not related to the declarant by blood or marriage, or adoption;

(b) Are not entitled to any portion of the estate of the declarant upon his/her death under any will of the declarant or codicil thereto then existing, or, at the time of the Directive, by operation of law then existing;

(c) Have no creditor's claim against the declarant, or anticipate making such claim against any portion of the estate of the declarant upon his or her death.

(d) Are not the attending physician, an employee of the attending physician, a health care provider, or an employee of a health care provider;

(e) Are not the operator of a community care facility or an employee of a community care facility.

The Directive shall be substantially in the form contained in Section 2525.24.

2525.4 SKILLED NURSING FACILITIES

A Directive shall have no force or effect if the declarant is a patient in a skilled nursing facility as defined in subdivision (c) of Section 1250 of the Health and Safety Code and intermediate care facility or community care facility at the time the Directive is executed unless one of the two witnesses to the Directive is a Patient Advocate or Ombudsman designated by the Department of Aging for this purpose pursuant to any other applicable provision of law. The Patient Advocate or Ombudsman shall have the same qualifications as a witness under Section 2525.3.

The intent of this paragraph is to recognize that some patients in skilled nursing facilities may be so insulated from a voluntary decision-making role, by virtue of the custodial nature of their care, as to require special assurance that they are capable of willingly and voluntarily executing a Directive.

2525.5. REVOCATION

A Directive may be revoked at any time by the declarant, without regard to his or her mental state or competency, by any of the following methods:

(a) By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by or at the direction of the declarant with the intent to revoke the Directive.

(b) By a written revocation of the declarant expressing his or her intent to revoke the Directive, signed and dated by the declarant. If the declarant is in a health care facility and under the care and management of a physician, the physician shall record in the patient's medical record the time and date when he or she received notification of the written revocation.

(c) By a verbal expression by the declarant of his or her intent to revoke the Directive. The revocation shall become effective only upon communication to the attending physician by the declarant. The attending physician shall confirm with the patient that he or she wishes to revoke, and shall record in the patient's medical record the time, date and place of the revocation.

There shall be no criminal, civil or administrative liability on the part of any health care provider for following a Directive that has been revoked unless that person has actual knowledge of the revocation.

2525.6 TERM OF DIRECTIVE

A Directive shall be effective unless and until revoked in the manner prescribed in Section 2525.5. This title shall not prevent a declarant from re-executing a Directive at any time in accordance with Section 2525.3, including re-execution subsequent to a diagnosis of a terminal condition.

2525.7 ADMINISTRATION OF AID-IN-DYING

When, and only when, a qualified patient determines that the time for physician aid-in-dying has arrived and has made an enduring request, the patient will communicate that determination directly to the attending physician who will administer aid-in-dying in accordance with this Act.

2525.8 NO COMPULSION

Nothing herein requires a physician to administer aid-in-dying, or a licensed health care professional, such as a nurse, to participate in administering aid-in-dying under the direction of a physician, if he or she is religiously, morally or ethically opposed. Neither shall privately owned hospitals be required to permit the administration of physician aid-in-dying in their facilities if they are religiously, morally or ethically opposed.

2525.9 PROTECTION OF HEALTH CARE PROFESSIONALS

No physician, health care facility or employee of a health care facility who, acting in accordance with the requirements of this title, administers aid-in-dying to a qualified patient shall be subject to civil, criminal, or administrative liability therefore. No licensed health care professional, such as a nurse, acting under the direction of a physician, who participates in the administration of aid-in-dying to a qualified patient in accordance with this title shall be subject to any civil, criminal, or administrative liability. No physician, or licensed health care professional acting under the direction of a physician, who acts in accordance with the provisions of this chapter, shall be guilty of any criminal act or of unprofessional conduct because he or she administers aid-in-dying.

2525.10 TRANSFER OF PATIENT

No physician, or health care professional or health care provider acting under the direction of a physician, shall be criminally, civilly, or administratively liable for failing to effectuate the Directive of the qualified patient, unless there is willful failure to transfer the patient to any physician, health care professional, or health care provider upon request of the patient.

2525.11 FEES

Fees, if any, for administering aid-in-dying shall be fair and reasonable.

2525.12 INDEPENDENT PHYSICIANS

The certifying physicians shall not be partners or shareholders in the same medical practice.

2525.13 CONSULTATIONS

An attending physician who is requested to give aid-in-dying may request a psychiatric or psychological consultation if that physician has any concern about the patient's competence, with the consent of a qualified patient.

2525.14 DIRECTIVE COMPLIANCE

Prior to administering aid-in-dying to a qualified patient, the attending physician shall take reasonable steps to determine that the Directive has been signed and witnessed, and all steps are in accord with the desires of the patient, expressed in the Directive and in their personal discussions. Absent knowledge to the contrary, a physician or other health care provider may presume the Directive complies with this title and is valid.

2525.15 MEDICAL STANDARDS

No physician shall be required to take any action contrary to reasonable medical standards in administering aid-in-dying.

2525.16 NOT **SUICIDE**

Requesting and receiving aid-in-dying by a qualified patient in accordance with this title shall not, for any purpose, constitute a **suicide**.

2525.17 INSURANCE

(a) No insurer doing business in California shall refuse to insure, cancel, refuse to renew, re-assess the risk of an insured, or raise premiums on the basis of whether or not the insured has considered or completed a Directive. No insurer may require or request the insured to disclose whether he or she has executed a Directive.

(b) The making of a Directive pursuant to Section 2525.3 shall not restrict, inhibit, or impair in any manner the sale, procurement, issuance or rates of any policy of life, health, or disability insurance, nor shall it affect in any way the terms of an existing policy of life, health or disability insurance. No policy of life, health, or disability insurance shall be legally impaired or invalidated in any manner by the administration of aid-in-dying to an insured qualified patient, notwithstanding any term of the policy to the contrary.

(c) No physician, health care facility, or other health care provider, and no health care service plan, insurer issuing disability insurance, other insurer, self-insured employee welfare benefit plan, or non-profit hospital service plan shall require any person to execute or prohibit any person from executing a Directive as a condition for being insured for, or receiving, health care services, nor refuse service because of the execution, the existence, or the revocation of a Directive.

(d) A person who, or a corporation, or other business which, requires or prohibits the execution of a Directive as a condition for being insured for, or receiving, health care services is guilty of a misdemeanor.

(e) No life insurer doing business in California may refuse to pay sums due upon the death of the insured whose death was assisted in accordance with this Act.

2525.18 INDUCEMENT

No patient may be pressured to make a decision to seek aid-in-dying because that patient is a financial, emotional or other burden to his or her family, other persons, or the state. A person who coerces, pressures or fraudulently induces another to execute a Directive under this chapter is guilty of a misdemeanor, or if death occurs as a result of said coercion, pressure or fraud, is guilty of a felony.

2525.19 TAMPERING

Any person who willfully conceals, cancels, defaces, obliterates, or damages the Directive of another without the declarant's consent shall be guilty of a misdemeanor. Any person who falsifies or forges the Directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in Section 2525.5, with the intent to induce aid-in-dying procedures contrary to the wishes of the declarant, and thereby, because of such act, directly causes aid-in-dying to be administered, shall be subject to prosecution for unlawful homicide as provided in Chapter 1 (commencing with Section 187) of Title 8 of Part 1 of the Penal Code.

2525.20 OTHER RIGHTS

This Act shall not impair or supersede any right or legal responsibility which any person may have regarding the withholding or withdrawal of life-sustaining procedures in any lawful manner.

2525.21 REPORTING

Hospitals and other health care providers who carry out the Directive of a qualified patient shall keep a record of the number of these cases, and report annually to the State Department of Health Services the patient's age, type of illness, and the date the Directive was carried out. In all cases, the identity of the patient shall be strictly confidential and shall not be reported.

2525.22 RECORDING

The Directive, or a copy of the Directive, shall be made a part of a patient's medical record in each institution involved in the patient's medical care.

2525.23 MERCY KILLING DISAPPROVED

Nothing in this Act shall be construed to condone, authorize, or approve mercy killing.

2525.24 FORM OF DIRECTIVE

In order for a Directive to be valid under this title, the Directive shall be in substantially the following form:

VOLUNTARY DIRECTIVE TO PHYSICIANS

NOTICE TO PATIENT:

This document will exist until it is revoked by you. This document revokes any prior Directive to administer aid-in-dying but does not revoke a durable power of attorney for health care or living will. You must follow the witnessing procedures described at the end of this form or the document will not be valid. You may wish to give your doctor a signed copy.

INSTRUCTIONS FOR PHYSICIANS

ADMINISTRATION OF A MEDICAL PROCEDURE TO END MY LIFE IN A PAINLESS, HUMANE, AND DIGNIFIED MANNER

This Directive is made this day of (month) (year).

I, , being of sound mind, do voluntarily make known my desire that my life shall be ended with the aid of a physician in a painless, humane, and dignified manner when I have a terminal condition or illness, certified to be terminal by two physicians, and they determine that my death will occur within six months or less.

When the terminal diagnosis is made and confirmed, and this Directive is in effect, I may then ask my attending physician for aid-in-dying. I trust and hope that he or she will comply. If he or she refuses to comply, which is his or her right, then I urge that he or she assist in locating a colleague who will comply.

Determining the time and place of my death shall be in my sole discretion. The manner of my death shall be determined jointly by my attending physician and myself.

This Directive shall remain valid until revoked by me. I may revoke this Directive at any time.

I recognize that a physician's judgment is not always certain, and that medical science continues to make progress in extending life, but in spite of these facts, I nevertheless wish aid-in-dying rather than letting my terminal condition take its natural course.

I will endeavor to inform my family of this Directive, and my intention to request the aid of my physician to help me to die when I am in a terminal condition, and take those opinions into consideration. But the final decision remains mine. I acknowledge that it is solely my responsibility to inform my family of my intentions.

I have given full consideration to and understand the full import of this Directive, and I am emotionally and mentally competent to make this Directive. I accept the moral and legal responsibility for receiving aid-in-dying.

This Directive will not be valid unless it is signed by two qualified witnesses who are *present when you sign or acknowledge your signature. The witnesses must not be related to you by blood, marriage, or adoption; they must not be entitled to any part of your estate or at the time of execution of the Directive have no claim against any portion of your estate, nor anticipate making such claim against any portion of your estate; and they must not include: your attending physician, an employee of the attending physician; a health care provider; an employee of a health care provider; the operator of the community care facility or an employee of an operator of a community care facility.*

If you have attached any additional pages to this form, you must sign and date each of the additional pages at the same time you date and sign this Directive.

Signed:

City, County, and State of Residence

STATEMENT OF WITNESSES

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of satisfactory evidence) to be the declarant of this Directive; that he or she signed and acknowledged this Directive in my presence, that he or she appears to be of sound mind and under no duress, fraud, or undue influence; that I am not the attending physician, an employee of the attending physician, a health care provider, an employee of a health care provider, the operator of a community care facility, or an employee of an operator of a community care facility.

I further declare under penalty of perjury under the laws of California that I am not related to the declarant by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law, and have no claim nor anticipate making a claim against any portion of the estate of the declarant upon his or her death.

Dated:

Witness's Signature:

Print Name:

Residence Address:

Dated:

Witness's Signature:

Print Name:

Residence Address:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

(If you are a patient in a skilled nursing facility, one of the witnesses must be a Patient Advocate or Ombudsman. The following statement is required only if you are a patient in a skilled nursing facility, a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The Patient Advocate or Ombudsman must sign the "Statement of Witnesses" above AND must also sign the following statement.)

I further declare under penalty of perjury under the laws of California that I am a Patient Advocate or Ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 2525.4 of the California Civil Code.

Signed:

SEC. 2. PENAL CODE AMENDMENT

Section 401 of the Penal Code is amended to read:

401. Suicide, aiding, advising or encouraging. Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony. Death resulting from a request for aid-in-dying pursuant to Title 10.5 (commencing with Section 2525) of Division 3 of Part 4 of the Civil Code shall not constitute suicide, nor is a licensed physician who lawfully administers aid-in-dying or a health care provider or licensed health care professional acting under the direction of a physician, liable under this section. Death resulting from aid-in-dying pursuant to a Directive in accordance with the Death With Dignity Act does not, for any purpose, constitute a homicide.

SEC. 3. AMENDMENT OF INITIATIVE

This Act may be amended only by a statute passed by a two-thirds vote of each house of the legislature and signed by the Governor.

Source: California Secretary of State

Appendix G

Proposal B

INITIATIVE OF LEGISLATION

AN ACT to amend 1978 PA 368, entitled "Public health code," by amending sections 2844, 5658, 5660, 7401, 16221, 16226, 17033, 17533, 17766, and 20165 (MCL 333.2844, 333.5658, 333.5660, 333.7401, 333.16221, 333.16226, 333.17033, 333.17533, 333.17766, and 333.20165), sections 5658 and 5660 as added and sections 16221 and 16226 as amended by 1996 PA 594, section 7401 as amended by 1996 PA 249, sections 17033 and 17533 as amended by 1994 PA 234, section 17766 as amended by 1990 PA 30, and section 20165 as amended by 1990 PA 179, and by adding part 56b entitled "Terminally Ill Patient's Right to End Unbearable Pain and Suffering Act"; to amend 1953 PA 181 (MCL 52.201-216), commonly referred to as the "Medical examiners act," by amending sections 2 and 3 (MCL 52.202 and 52.203), to amend 1976 PA 267, entitled "Open meetings act," by amending section 3(MCL 15.263), as amended by 1988 PA 278, and to repeal acts and parts of acts.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2844. (1) *[When]* IF death occurs more than 10 days after the deceased was last seen by a physician, if the cause of death appears to be other than the illness or condition for which deceased was being treated, or if the attending physician cannot accurately determine the cause of death, the case shall be referred to the county medical examiner for investigation to determine and certify the cause of death. If the county medical examiner determines that the case does not fall within his or her jurisdiction, the county medical examiner shall refer the case back to the deceased's physician within 24 hours for completion of the medical certification. IN ACCORDANCE WITH SECTION 5686(1), IF AN INDIVIDUAL HAS DIED AS A RESULT OF THE PROCEDURES AUTHORIZED UNDER PART 56B, THEN FOR PURPOSES OF THIS SUBSECTION, THE CAUSE OF DEATH IS THE TERMINAL ILLNESS FOR WHICH THE DECEASED WAS BEING TREATED.

(2) *[When]* IF an investigation is required under ACT *[No. 181 of the Public Acts of 1953, as amended, being Sections 52.201 to 52.216 of the Michigan Compiled Laws]* 1953 PA 181, MCL 52.201 TO 52.216, the county medical examiner shall determine the cause of death and shall complete and sign the medical certification within 48 hours after taking charge of the case.

(3) If the cause of death cannot be determined within 48 hours after death, the medical certification may be completed as provided by the department. The attending physician or county medical examiner shall give the funeral director in custody of the body notice of the reason for the delay, and final disposition shall not be made until authorized by the attending physician or medical examiner.

Sec. 5658. A physician who, as part of a medical treatment plan for a terminally ill patient, prescribes for the terminally ill patient a controlled substance that is included in schedules 2 to 5 under part 72 and that is a narcotic *[drug is immune from]* administrative and civil liability based on prescribing the controlled substance if the prescription is given in good faith and with the intention to treat a patient with a terminal illness or alleviate the patient's pain, or both, OR TO COMPLY WITH A REQUEST MADE IN COMPLIANCE WITH PART 56B and all of the following are met:

(a) The prescription is for a legitimate legal and professionally recognized therapeutic purpose OR IS WRITTEN PURSUANT TO A REQUEST MADE IN COMPLIANCE WITH PART 56B.
(b) Prescribing the controlled substance is within the scope of practice of the physician.
(c) The physician holds a valid license under article 7 to prescribe controlled substances.

Sec. 5660. This part does not do the following:

(a) Impair or supersede a legal right a parent, patient, advocate, legal guardian, or other individual may have to consent to or refuse medical treatment on behalf of another.

(b) *[create]* CREATE a presumption about a terminally ill patient's desire to receive or refuse medical treatment, regardless of the ability of the patient to participate in medical treatment decisions.

(c) Limit the ability of a court making a determination about a terminally ill patient's medical treatment decisions to take into consideration all of the following state interests:

(i) The preservation of life.
(ii) The prevention of suicide. THIS SUBPARAGRAPH DOES NOT INCLUDE THE DEATH OF AN INDIVIDUAL WHO ENDED HIS OR HER LIFE BY USING THE PROCEDURES AUTHORIZED BY PART 56B.
(iii) The protection of innocent third parties.
(iv) The preservation of the integrity of the medical profession.
(d) Condone, authorize, or approve suicide, assisted suicide, mercy killing, or euthanasia. THIS SUBDIVISION DOES NOT AFFECT THE OPERATION OF PART 56B.

PART 56B

TERMINALLY ILL PATIENT'S RIGHT TO END UNBEARABLE PAIN OR SUFFERING

SEC. 5671. THIS PART SHALL BE KNOWN AND MAY BE CITED AS THE "TERMINALLY ILL PATIENT'S RIGHT TO END UNBEARABLE PAIN OR SUFFERING ACT".

SEC. 5672. IT IS THE INTENT OF THE PEOPLE IN ENACTING THIS PART TO DO ALL OF THE FOLLOWING:

(A) GIVE A TERMINALLY ILL ADULT WHO IS COMPETENT, FULLY INFORMED, AND A RESIDENT OF THIS STATE, OR A CLOSE RELATIVE OF A RESIDENT OF THIS STATE, THE RIGHT TO END UNBEARABLE PAIN OR SUFFERING THROUGH THE SELF-ADMINISTRATION OF MEDICATION TO HASTEN DEATH;

(B) ASSURE THE PATIENT'S RIGHT TO REVOKE HIS OR HER REQUEST FOR MEDICATION AT ANY TIME AND NUMEROUS OTHER PATIENT SAFEGUARDS;

(C) MAINTAIN CONFIDENTIALITY OF PATIENT RECORDS AT ALL TIMES;
(D) PROTECT OTHER LEGAL RIGHTS OF A PATIENT WHO COMPLIES WITH THIS ACT;

(E) PROVIDE OVERSIGHT OF PHYSICIAN'S WHO PRESCRIBE MEDICATION PURSUANT TO THIS ACT; AND

(F) PUNISH A PHYSICIAN OR OTHER INDIVIDUAL WHO VIOLATES THIS ACT.

SEC. 5673. AS USED IN THIS PART:

(A) "ADULT" MEANS AN INDIVIDUAL WHO IS 18 YEARS OF AGE OR OLDER.
(B) "ATTENDING PHYSICIAN" MEANS A PHYSICIAN WHO HAS PRIMARY RESPONSIBILITY FOR THE CARE OF THE PATIENT.

(C) "COMPETENT" MEANS THE ABILITY TO MAKE PERSONAL MEDICAL DECISIONS BASED UPON AN UNDERSTANDING OF THE RELEVANT ASPECTS OF A PATIENT'S CURRENT MEDICAL CIRCUMSTANCES, AND UNDERSTANDING OF THE BENEFITS, RISKS, AND LIKELY CONSEQUENCES OF THE TREATMENT ALTERNATIVES DESCRIBED IN THIS PART, AND THE ABILITY TO ARRIVE AT AN INDEPENDENT AND SUSTAINED DECISION BASED UPON THE PATIENT'S RATIONAL CHOICE.

(D) "CONSULTING PHYSICIAN" MEANS A PHYSICIAN WHO SPECIALIZES IN THE DISEASE THAT HAS CAUSED A PATIENT TO BECOME TERMINAL, IS ACTIVELY PRACTICING THAT SPECIALTY, AND IS CERTIFIED BY AN NATIONAL PROFESSIONAL ORGANIZATION FOR THAT SPECIALTY AND APPROVED BY THAT PHYSICIAN'S LICENSING BOARD.

(E) "DEPARTMENT" MEANS THE DEPARTMENT OF COMMUNITY HEALTH.
(F) "HEALTH CARE PROVIDER" MEANS A PERSON LICENSED, REGISTERED, OR OTHERWISE AUTHORIZED OR PERMITTED BY THE LAW OF THIS STATE TO PROVIDE HEALTH CARE IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A HEALTH PROFESSION. HEALTH CARE PROVIDER INCLUDES A

HEALTH FACILITY.
(G) "HEALTH FACILITY" MEANS A HEALTH FACILITY OR AGENCY LICENSED UNDER ARTICLE 17.

(H) "INFORMED DECISION" MEANS A DECISION BY A PATIENT TO REQUEST A PRESCRIPTION UNDER THIS ACT FOR MEDICATION TO END HIS OR HER UNBEARABLE PAIN OR SUFFERING BY ENDING HIS OR HER LIFE IN A HUMANE AND DIGNIFIED MANNER THAT IS MADE AFTER BEING FULLY INFORMED BY THE PATIENT'S ATTENDING PHYSICIAN OR A CONSULTING PHYSICIAN UNDER THIS PART OF ALL OF THE FOLLOWING:

(i) THE PATIENT'S MEDICAL DIAGNOSIS.
(ii) THE PATIENT'S PROGNOSIS.
(iii) THE POTENTIAL RISKS ASSOCIATED WITH TAKING THE MEDICATION TO BE PRESCRIBED.
(iv) THE PROBABLE RESULT OF TAKING THE MEDICATION TO BE PRESCRIBED.
(v) THE ALTERNATIVES TO TAKING THE MEDICATION PRESCRIBED, INCLUDING, BUT NOT LIMITED TO, COMFORT CARE, HOSPICE CARE, AND PAIN CONTROL.
(vi) THAT THE PATIENT MAY RESCIND THE DECISION AT ANY TIME BY EITHER WRITTEN OR ORAL COMMUNICATION OR IN ANY MANNER THAT COMMUNICATES THE SAME INTENT.

(I) "MEDICATION" MEANS 1 OR MORE PRESCRIPTION DRUGS THAT CAN BE TAKEN ORALLY OR BY NASOGASTRIC OR GASTROSTOMY TUBE.
(J) "PATIENT" MEANS AN INDIVIDUAL WHO IS AN ADULT RESIDENT AND WHO IS UNDER THE CARE OF AN ATTENDING PHYSICIAN AND IS BEING TREATED BY THAT PHYSICIAN OR BY A CONSULTING PHYSICIAN FOR A TERMINAL ILLNESS.

(K) "PATIENT'S MEDICAL RECORD" MEANS BOTH OF THE FOLLOWING:

(i) FOR A PATIENT WHO IS AN INPATIENT OR AN OUTPATIENT IN A HEALTH FACILITY, THE PERMANENT RECORD OF THE MEDICAL CARE AND TREATMENT RECEIVED BY THE PATIENT IN OR FROM THAT HEALTH FACILITY, WHICH RECORD IS REQUIRED TO BE COMPILED AND MAINTAINED BY THE HEALTH FACILITY UNDER SECTION 20175 AND BY PROFESSIONAL STANDARDS OF PRACTICE.
(ii) FOR A PATIENT WHO IS NOT AN INPATIENT OR OUTPATIENT IN A HEALTH FACILITY, BUT IS RECEIVING MEDICAL CARE AND TREATMENT FROM A LICENSED HEALTH PROFESSIONAL, THE PERMANENT RECORD OF THE MEDICAL CARE AND TREATMENT RECEIVED BY THE PATIENT FROM THE LICENSED HEALTH PROFESSIONAL, WHICH RECORD IS REQUIRED TO BE COMPILED AND MAINTAINED BY THE LICENSED HEALTH PROFESSIONAL BY

LAW AND BY PROFESSIONAL STANDARDS OF PRACTICE.
(L) "PHARMACIST" MEANS AN INDIVIDUAL LICENSED UNDER ARTICLE 15 TO ENGAGE IN THE PRACTICE OF PHARMACY.
(M) "PHYSICIAN" MEANS AN ALLOPATHIC OR OSTEOPATHIC PHYSICIAN LICENSED TO ENGAGE IN THE PRACTICE OF MEDICINE OR THE PRACTICE OF OSTEOPATHIC MEDICINE AND SURGERY UNDER ARTICLE 15.
(N) "PRESCRIPTION DRUG" MEANS THAT TERM AS DEFINED IN SECTION 17708, AND INCLUDES, BUT IS NOT LIMITED TO, A CONTROLLED SUBSTANCE AS DEFINED IN SECTION 7104.
(0) "PSYCHIATRIST" MEANS A PHYSICIAN WHO SPECIALIZES IN PSYCHIATRY.
(P) "REQUEST" MEANS A REQUEST FOR MEDICATION UNDER THIS PART FOR SELF-ADMINISTRATION THE PRIMARY PURPOSE OF WHICH IS TO HASTEN OR CAUSE THE DEATH OF THE REQUESTER AND THAT MEETS THE REQUIREMENTS OF SECTION 5675.
(Q) "RESIDENT" MEANS AN INDIVIDUAL WHO RESIDES IN THIS STATE AT THE TIME OF MAKING A REQUEST UNDER THIS PART AND WHO HAS RESIDED IN THIS STATE FOR NOT LESS THAN THE 6 MONTHS IMMEDIATELY PRECEDING THE DATE OF MAKING THE REQUEST. FOR PURPOSES OF THIS PART ONLY, RESIDENT INCLUDES A PARENT OF A RESIDENT, ADULT SIBLING OF A RESIDENT, ADULT CHILD OF A RESIDENT, OR A SPOUSE OF 1 OF THOSE INDIVIDUALS WHO DOES NOT RESIDE IN THIS STATE, IF THE RELATIONSHIP TO THE RESIDENT IS ATTESTED TO BY AFFIDAVIT OF THE RESIDENT PRESENTED TO AN ATTENDING PHYSICIAN. FOR PURPOSES OF THIS PART ONLY, THE PARENT, ADULT SIBLING, ADULT CHILD, OR SPOUSE OF 1 OF THOSE INDIVIDUALS IS CONSIDERED A RESIDENT OF THE COUNTY OF RESIDENCE OF THE RESIDENT PRESENTING THE AFFIDAVIT.

(R) "SELF-ADMINISTRATION" MEANS THE INSERTION OR INGESTION OF MEDICATION REQUESTED UNDER THIS PART, INCLUDING ACCOMPANYING FLUIDS, THAT IS PERFORMED ENTIRELY UNDER A PATIENT’S OWN EFFORT.

(S) "SIGNIFICANT OTHER" MEANS AN INDIVIDUAL WHO HAS HAD A MONOGAMOUS-TYPE RELATIONSHIP WITH A PATIENT FOR NOT LESS THAN 1 YEAR.
(T) "SUFFERING" MEANS THE PHYSICAL OR MENTAL TORMENT CAUSED BY A TERMINAL ILLNESS AND THAT RESULTS FROM THE PROGRESSIVE AND SERIOUS LOSS OF THE ABILITY TO PERFORM MAJOR LIFE FUNCTIONS.
(U) "TERMINAL ILLNESS" MEANS AN INCURABLE AND IRREVERSIBLE DISEASE THAT IS MEDICALLY CONFIRMED AND THAT WILL, WITHIN REASONABLE MEDICAL JUDGMENT, RESULT IN THE DEATH OF THE PATIENT WITHIN 6 MONTHS OR LESS.
(V) "TERMINAL PERIOD" MEANS THE LAST 6 MONTHS OF LIFE FOR A PATIENT WITH A TERMINAL ILLNESS, WITHIN REASONABLE MEDICAL JUDGMENT.

INDEPENDENT JUDGMENT WITHOUT EVIDENCE OF OUTSIDE COERCION, INSOFAR AS CAN BE REASONABLY DETERMINED BY THE PATIENT'S ATTENDING PHYSICIAN OR BY A CONSULTING PHYSICIAN OR BY A PSYCHIATRIST.

SEC. 5674. (1) A PATIENT WHO MEETS ALL OF THE FOLLOWING REQUIREMENTS MAY MAKE A REQUEST UNDER THIS PART DURING THE TERMINAL PERIOD FOR MEDICATION FOR SELF-ADMINISTRATION, THE PRIMARY PURPOSE OF WHICH IS TO END THE PATIENT'S UNBEARABLE PAIN OR SUFFERING BY ENDING HIS OR HER LIFE IN A HUMANE AND DIGNIFIED MANNER:

(A) IS COMPETENT AND HAS MADE AN INFORMED DECISION.

(B) IS DETERMINED BY THE PATIENT'S ATTENDING PHYSICIAN AND BY A CONSULTING PHYSICIAN TO BE SUFFERING FROM A TERMINAL ILLNESS.

(C) HAS VOLUNTARILY EXPRESSED HIS OR HER WISH TO DIE BY MEANS OF MAKING A REQUEST UNDER THIS PART PURSUANT TO AN INFORMED DECISION.
(2) AN INDIVIDUAL IS NOT QUALIFIED TO MAKE A REQUEST SOLELY BECAUSE OF AGE OR DISABILITY, OR A COMBINATION OF AGE AND DISABILITY, OTHER THAN A DISABILITY CAUSED BY A TERMINAL ILLNESS.

SEC. 5675. (1) A REQUEST MAY BE IN WRITING OR, IF THE PATIENT IS UNABLE TO WRITE, MAY BE MADE ORALLY AND SHALL CONTAIN ALL OF THE FOLLOWING INFORMATION:

(A) THE PATIENT'S FULL NAME AND HIS OR HER ADDRESS AT THE TIME THE REQUEST IS MADE. IF THE PATIENT IS AN INPATIENT OR A RESIDENT IN A HEALTH FACILITY, THE REQUEST SHALL CONTAIN THE PATIENT'S LAST KNOWN RESIDENTIAL ADDRESS.

(B) A STATEMENT THAT THE PATIENT BELIEVES HIMSELF OR HERSELF TO BE COMPETENT.
(C) A STATEMENT THAT THE REQUEST IS BEING MADE VOLUNTARILY AND WITHOUT COERCION.
(D) A DESCRIPTION OF THE TERMINAL ILLNESS FROM WHICH THE PATIENT IS SUFFERING.
(E) A STATEMENT THAT THE PATIENT HAS BEEN INFORMED BY HIS OR HER ATTENDING PHYSICIAN THAT THE TERMINAL ILLNESS WILL LIKELY PRODUCE DEATH WITHIN 6 MONTHS OR LESS.
(F) A STATEMENT THAT THE PATIENT HAS BEEN INFORMED BY HIS OR HER ATTENDING PHYSICIAN OR CONSULTING PHYSICIAN REGARDING COMFORT CARE, HOSPICE CARE, AND PAIN CONTROL.

(G) A STATEMENT THAT THE PATIENT UNDERSTANDS THAT HE OR SHE MAY RESCIND THE REQUEST AT ANY TIME AND BY ANY METHOD OF COMMUNICATION.

(2) THE PATIENT SHALL SIGN AND DATE A REQUEST MADE UNDER SUBSECTION (1) THAT IS IN WRITING.

(3) A REQUEST MADE UNDER SUBSECTION (1) THAT IS IN WRITING SHALL BE WITNESSED BY AT LEAST 2 INDIVIDUALS WHO ATTEST THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF THE PATIENT IS RATIONAL AND IS ACTING VOLUNTARILY. AT LEAST 1 OF THE WITNESSES REQUIRED UNDER THIS SUBSECTION SHALL NOT BE 1 OR MORE OF THE FOLLOWING:

(A) A RELATIVE OF THE QUALIFIED PATIENT BY BLOOD, MARRIAGE, OR ADOPTION.

(B) KNOWINGLY ENTITLED AT THE TIME THE REQUEST IS SIGNED TO HAVE CONTROL OVER A PORTION OF THE ESTATE OF THE PATIENT UPON THE PATIENT’S DEATH UNDER A WILL OR TRUST, OR BY OPERATION OF LAW.

(C) AN OWNER, OPERATOR, OR EMPLOYEE OF A HEALTH FACILITY WHERE THE PATIENT IS RECEIVING MEDICAL TREATMENT OR IS A RESIDENT.

(4) THE PATIENT’S ATTENDING PHYSICIAN AT THE TIME THE REQUEST IS SIGNED SHALL NOT BE A WITNESS UNDER SUBSECTION (3).

(5) IF A PATIENT IS A PATIENT IN A HEALTH FACILITY AT THE TIME A REQUEST IS MADE, 1 OF THE WITNESSES REQUIRED UNDER SUBSECTION (3) SHALL BE AN INDIVIDUAL DESIGNATED BY THE HEALTH FACILITY, BUT WHO IS NOT EMPLOYED BY OR UNDER CONTRACT TO THE HEALTH FACILITY.

(6) IF THE PATIENT HAS MADE AN ORAL REQUEST, THE REQUEST SHALL BE RECORDED BY VIDEO MEANS.

SEC. 5676. (1) WHETHER OR NOT A PATIENT HAS MADE A REQUEST, THE ATTENDING PHYSICIAN OR, IF THE ATTENDING PHYSICIAN HAS NOT DONE SO, THE CONSULTING PHYSICIAN SHALL DO ALL OF THE FOLLOWING AS SOON AS POSSIBLE AFTER DETERMINING THAT THE PATIENT HAS A TERMINAL ILLNESS:

(A) UPON REQUEST OF THE PATIENT, PROVIDE THE PATIENT WITH A TRUE COPY OF THIS PART AND WITH A COPY OF THE BOOKLET PRODUCED BY THE DEPARTMENT UNDER SECTION 5682.

(B) INFORM THE PATIENT REGARDING COMFORT CARE, HOSPICE CARE, AND PAIN MANAGEMENT.

(C) ASK THE PATIENT WHETHER HE OR SHE HAS QUESTIONS REGARDING PAYMENT FOR THE TREATMENT THE ATTENDING PHYSICIAN OR THE CONSULTING PHYSICIAN HAS PROVIDED OR WILL PROVIDE FOR THE

TERMINAL ILLNESS OR PAYMENT FOR COMFORT CARE, HOSPICE CARE, OR PAIN CONTROL. IF THE PATIENT HAS SUCH QUESTIONS, THE ATTENDING PHYSICIAN OR THE CONSULTING PHYSICIAN SHALL REFER THE PATIENT TO A PROFESSIONAL WHO CAN IDENTIFY POSSIBLE FINANCIAL ASSISTANCE FOR THE PATIENT.

(2) IN ADDITION TO COMPLYING WITH SECTIONS 5654 AND 5655, A PATIENT'S ATTENDING PHYSICIAN SHALL DO ALL OF THE FOLLOWING IN RELATION TO A REQUEST BEFORE WRITING A PRESCRIPTION UNDER THE REQUEST AND PURSUANT TO THIS PART:

(A) CONFIRM THE INITIAL DETERMINATION THAT THE PATIENT HAS A TERMINAL ILLNESS, IS COMPETENT, AND IS MAKING THE REQUEST VOLUNTARILY AND PURSUANT TO AN INFORMED DECISION.
(B) INFORM THE PATIENT OF ALL OF THE FOLLOWING:

(i) THAT THE ATTENDING PHYSICIAN HAS CONFIRMED THAT THE PATIENT HAS A TERMINAL ILLNESS.
(ii) THE PATIENT'S PROGNOSIS.
(iii) THE POTENTIAL RISKS ASSOCIATED WITH TAKING THE MEDICATION TO BE PRESCRIBED UNDER THE REQUEST.
(iv) THE PROBABLE RESULT OF TAKING THE MEDICATION TO BE PRESCRIBED UNDER THE REQUEST.
(v) THE ALTERNATIVES TO MAKING A REQUEST, INCLUDING, BUT NOT LIMITED TO, COMFORT CARE, HOSPICE CARE, PAIN CONTROL, SEDATION COMA, REFUSAL OF HYDRATION AND NUTRITION, AND WITHDRAWAL OF LIFE-SUSTAINING TREATMENT, AS APPROPRIATE.

(C) REQUIRE THE PATIENT TO CONSULT WITH A PSYCHIATRIST. THE PSYCHIATRIST SHALL INTERVIEW THE PATIENT AND REVIEW THE PATIENT'S RELEVANT MEDICAL RECORDS. IF THE PSYCHIATRIST DETERMINES BOTH OF THE FOLLOWING, HE OR SHE SHALL DOCUMENT THAT DETERMINATION IN THE PATIENT'S MEDICAL RECORD AND SHALL ISSUE THE PATIENT A WRITTEN STATEMENT OF THE DETERMINATION, THAT THE PATIENT SHALL PRESENT TO HIS OR HER ATTENDING PHYSICIAN:

(i) THAT THE PATIENT HAS NO DIAGNOSABLE MENTAL DISORDER OR, IF THE PATIENT DOES HAVE A DIAGNOSABLE MENTAL DISORDER, THAT THE REQUEST FOR MEDICATION UNDER THIS PART IS NOT THE RESULT OF A DISTORTION OF THE PATIENT'S JUDGMENT DUE TO CLINICAL DEPRESSION OR ANOTHER MENTAL ILLNESS.
(ii) THAT THE REQUEST IS REASONED, IS FULLY INFORMED, AND IS VOLUNTARY, AS FAR AS CAN REASONABLY BE DETERMINED.

(D) REFER THE PATIENT TO THE PATIENT'S CONSULTING PHYSICIAN OR, IF

NONE IS INVOLVED, TO ANOTHER CONSULTING PHYSICIAN WHO SPECIALIZES IN TREATING THE TERMINAL ILLNESS FROM WHICH THE PATIENT IS SUFFERING FOR MEDICAL CONFIRMATION OF THE DIAGNOSIS MADE UNDER SUBDIVISION (B)(i), AND FOR AN INDEPENDENT DETERMINATION THAT THE PATIENT IS COMPETENT AND IS MAKING THE REQUEST VOLUNTARILY AND PURSUANT TO AN INFORMED DECISION, AND IS INFORMED REGARDING SEDATION COMA, REFUSAL OF HYDRATION AND NUTRITION, AND WITHDRAWAL OF LIFE-SUSTAINING TREATMENT, AS APPROPRIATE. IF THE PATIENT'S TERMINAL ILLNESS IS CANCER, THE ATTENDING PHYSICIAN SHALL REFER THE PATIENT TO A CONSULTING PHYSICIAN WHO SPECIALIZES IN ONCOLOGY.

(E) INFORM THE PATIENT AT THE TIME THE REQUEST IS MADE THAT HE OR SHE HAS THE RIGHT TO RESCIND THE REQUEST AT ANY TIME AND BY ANY METHOD OF COMMUNICATION.
(F) IMMEDIATELY BEFORE WRITING THE PRESCRIPTION FOR THE REQUESTED MEDICATION, VERIFY THAT THE PATIENT IS MAKING THE REQUEST VOLUNTARILY AND PURSUANT TO AN INFORMED DECISION.
(G) FULFILL THE MEDICAL RECORD DOCUMENTATION REQUIREMENTS OF SECTION 5681.
(H) ENSURE THAT ALL REQUIRED STEPS ARE CARRIED OUT IN ACCORDANCE WITH THIS PART BEFORE WRITING A PRESCRIPTION FOR MEDICATION UNDER THIS PART.
(3) A PHYSICIAN SHALL NOT ESTABLISH A CLINIC THAT EXCLUSIVELY PROVIDES THE PROCEDURES AUTHORIZED UNDER THIS PART.
(4) AN ATTENDING PHYSICIAN SHALL CONFORM HIS OR HER CONDUCT TO THE APPLICABLE STANDARD OF PRACTICE AT ALL TIMES WHILE PROVIDING THE SERVICES, MAKING THE DETERMINATIONS, AND FOLLOWING THE PROCEDURES AUTHORIZED UNDER THIS PART.
(5) A LICENSED PHYSICIAN SPECIALIZING IN PSYCHIATRY WHO INTERVIEWS A PATIENT UNDER SUBSECTION (2)(C) SHALL CONFORM HIS OR HER CONDUCT TO THE APPLICABLE STANDARD OF PRACTICE IN MAKING THE DETERMINATIONS REQUIRED UNDER SUBSECTION (2)(C).

SEC. 5677. (1) AFTER A PATIENT HAS BEEN REFERRED TO A CsONSULTING PHYSICIAN UNDER SECTION 5676(2)(D), THE CONSULTING PHYSICIAN SHALL EXAMINE THE PATIENT AND THE PATIENT'S RELEVANT MEDICAL RECORDS. IF THE CONSULTING PHYSICIAN CONCURS WITH THE ATTENDING PHYSICIAN, HE OR SHE SHALL CONFIRM, IN WRITING IN THE PATIENT'S MEDICAL RECORD, THE ATTENDING PHYSICIAN'S DIAGNOSIS THAT THE PATIENT IS SUFFERING FROM A TERMINAL ILLNESS, AND SHALL VERIFY THAT THE PATIENT IS COMPETENT AND IS MAKING THE REQUEST VOLUNTARILY AND PURSUANT TO AN INFORMED DECISION. THE CONSULTING PHYSICIAN SHALL CONFORM HIS OR HER CONDUCT TO THE

REQUIRED UNDER THIS SECTION.

(2) IF THE CONSULTING PHYSICIAN WRITES THE PRESCRIPTION FOR THE REQUESTED MEDICATION, HE OR SHE SHALL ASSURE THAT THE REQUIREMENTS OF SECTIONS 5676, 5679, AND 5681 ARE MET.

SEC. 5678. IF AN ATTENDING PHYSICIAN OR A CONSULTING PHYSICIAN IS UNWILLING TO PERFORM 1 OR MORE OF THE DUTIES PRESCRIBED UNDER THIS PART, INCLUDING, BUT NOT LIMITED TO, GIVING A PATIENT A TRUE COPY OF THIS PART OR A COPY OF THE BOOKLET PRODUCED BY THE DEPARTMENT UNDER SECTION 5682, PRESCRIBING MEDICATION PURSUANT TO A REQUEST, OR PERFORMING A REQUIRED EXAMINATION, THE ATTENDING PHYSICIAN OR CONSULTING PHYSICIAN SHALL IMMEDIATELY INFORM THE PATIENT OF THAT FACT AND SHALL TRANSMIT A COPY OF THE PATIENT'S RELEVANT MEDICAL RECORDS TO A PHYSICIAN OF THE PATIENT'S CHOICE WITHIN 72 HOURS. THE PHYSICIAN CHOSEN BY THE PATIENT BECOMES THE PATIENT'S ATTENDING PHYSICIAN OR CONSULTING PHYSICIAN, AS APPROPRIATE.

SEC. 5679. (1) A PATIENT WHO HAS MADE A REQUEST TO AN ATTENDING PHYSICIAN SHALL REITERATE THE REQUEST AFTER ALL OF THE REQUIREMENTS OF SECTIONS 5674 TO 5677 HAVE BEEN MET. WHEN THE PATIENT MAKES THE SECOND REQUEST UNDER THIS SUBSECTION, THE ATTENDING PHYSICIAN SHALL AT THAT TIME OFFER THE PATIENT AN OPPORTUNITY TO RESCIND THE REQUEST. IF THE PATIENT DOES NOT RESCIND THE REQUEST, THE ATTENDING PHYSICIAN SHALL ENTER THE SECOND REQUEST IN THE PATIENT'S MEDICAL RECORD.

(2) IF NOT LESS THAN 7 DAYS HAVE PASSED SINCE THE PATIENT'S INITIAL REQUEST, THE ATTENDING PHYSICIAN OR THE CONSULTING PHYSICIAN SHALL PRESCRIBE IN WRITING THE MEDICATION TO THE PATIENT AND THE PATIENT MAY OBTAIN THE MEDICATION FOR SELF-ADMINISTRATION THE PRIMARY PURPOSE OF WHICH IS TO END THE PATIENT'S UNBEARABLE PAIN OR SUFFERING BY ENDING THE PATIENT'S LIFE. THE PRESCRIPTION SHALL MEET ALL OF THE FOLLOWING REQUIREMENTS:

(A) BE PROVIDED ON THE SAME OFFICIAL PRESCRIPTION FORM THAT IS REQUIRED FOR THE PRESCRIPTION OF CONTROLLED SUBSTANCES INCLUDED IN SCHEDULE 2 UNDER ARTICLE 7. THE ATTENDING PHYSICIAN SHALL GIVE THE PATIENT THE OFFICIAL PRESCRIPTION FORM AND SHALL ENTER THE NAME OF THE MEDICATION, DOSAGE, AND QUANTITY PRESCRIBED AND THE INSTRUCTIONS FOR USE IN THE PATIENT'S MEDICAL RECORD IN THE MANNER REQUIRED BY SECTION 7334. THE ATTENDING PHYSICIAN SHALL RETAIN THAT PART OF THE MEDICAL RECORD FOR NOT LESS THAT 5 YEARS.

(B) BE FOR ONLY A SINGLE DOSE OF THE QUANTITY OF THE MEDICATION ESTIMATED TO CAUSE DEATH.
(C) CONTAIN DIRECTIONS THAT SPECIFY ONLY THE DOSE THAT WILL HASTEN OR CAUSE DEATH.
(D) BE LABELED WITH A STATEMENT THAT THE PRESCRIPTION WAS ISSUED PURSUANT TO THIS PART.
(E) BE LABELED WITH A PROMINENT CAUTIONARY STATEMENT THAT ADMINISTRATION OF THE PRESCRIBED DOSE IS LIKELY TO CAUSE DEATH.
(F) BE DISPENSED ONLY TO THE PATIENT OR TO AN AGENT OF THE PATIENT WITH APPROPRIATE IDENTIFICATION.
(3) A PHARMACIST WHO FILLS THE PRESCRIPTION SHALL CONFIRM THE DOSE WITH THE PRESCRIBING PHYSICIAN BEFORE DISPENSING THE MEDICATION TO THE PATIENT. THE PHARMACIST SHALL SIGN THE OFFICIAL PRESCRIPTION FORM AND FORWARD IT OR TRANSMIT THE INFORMATION ON THE OFFICIAL PRESCRIPTION FORM TO THE DEPARTMENT, AND SHALL RETAIN THE OFFICIAL PRESCRIPTION FORM OR A COPY OF THE FORM IN COMPLIANCE WITH SECTION 7334.
(4) NOTWITHSTANDING SECTION 7334(10) AND (11), THE FORM OR THE INFORMATION TRANSMITTED TO THE DEPARTMENT UNDER SUBSECTION (3) IS NOT A PUBLIC RECORD, IS NOT AVAILABLE FOR INSPECTION BY THE PUBLIC, AND IS NOT SUBJECT TO DISCLOSURE UNDER THE FREEDOM OF INFORMATION ACT, 1976 PA 442, MCL 15.231 TO 15.246.

SEC.5680. A PATIENT MAY RESCIND A REQUEST AT ANY TIME AND IN ANY MANNER BY WHICH HE OR SHE CAN COMMUNICATE AN INTENT TO RESCIND THE REQUEST, WITHOUT REGARD TO HIS OR HER MENTAL OR EMOTIONAL STATE.

SEC. 5681. (1)THE ATTENDING PHYSICIAN SHALL DOCUMENT IN WRITING AND FILE ALL OF THE FOLLOWING IN A PATIENT’S MEDICAL RECORD:

(A) EACH ORAL REQUEST MADE BY THE PATIENT.
(B) EACH WRITTEN REQUEST MADE BY THE PATIENT.

(C) THE ATTENDING PHYSICIAN’S DIAGNOSIS THAT THE PATIENT HAS A TERMINAL ILLNESS, THE PROGNOSIS, AND THE DETERMINATION THAT THE PATIENT IS COMPETENT AND IS MAKING THE REQUEST VOLUNTARILY AND PURSUANT TO AN INFORMED DECISION.

(D) THE CONSULTING PHYSICIAN’S CONFIRMATION OF THE ATTENDING PHYSICIAN’S DIAGNOSIS AND PROGNOSIS, AND THE CONSULTING PHYSICIAN’S INDEPENDENT VERIFICATION THAT THE PATIENT IS COMPETENT AND IS MAKING THE REQUEST VOLUNTARILY AND PURSUANT TO AN INFORMED DECISION AND THAT THE PATIENT IS INFORMED REGARDING SEDATION COMA, REFUSAL OF HYDRATION AND NUTRITION,

AND WITHDRAWAL OF LIFE-SUSTAINING TREATMENT, AS APPROPRIATE.

(E) THE WRITTEN STATEMENT FROM THE PSYCHIATRIST CONSULTED BY THE PATIENT AS REQUIRED UNDER SECTION 5676(2)(C).

(F) THE ATTENDING PHYSICIAN'S OFFER TO THE PATIENT OF AN OPPORTUNITY TO RESCIND THE REQUEST MADE UNDER SECTION 5679.

(G) A NOTE BY THE ATTENDING PHYSICIAN INDICATING THAT ALL REQUIREMENTS OF THIS PART HAVE BEEN MET AND THE STEPS TAKEN TO CARRY OUT THE REQUEST, INCLUDING, BUT NOT LIMITED, TO A NOTATION OF THE MEDICATION PRESCRIBED.

(2) THE ATTENDING PHYSICIAN SHALL RETAIN THAT PART OF A PATIENT'S MEDICAL RECORD REQUIRED TO BE KEPT UNDER SUBSECTION (1) FOR NOT LESS THAN 3 YEARS.

SEC. 5682. (1) WITHIN 60 DAYS AFTER THE EFFECTIVE DATE OF THIS PART, THE DEPARTMENT, IN CONSULTATION WITH THE OVERSIGHT COMMITTEE APPOINTED IN SECTION 5685, SHALL DEVELOP AND PUBLISH A BOOKLET THAT CONTAINS ALL OF THE FOLLOWING INFORMATION:

(A) THE PROCEDURE FOR MAKING A REQUEST AND OBTAINING MEDICATION UNDER THIS PART.
(B) THE AVAILABILITY OF MEDICATION UNDER THIS PART.
(C) ALTERNATIVES TO MAKING A REQUEST UNDER THIS PART, INCLUDING, BUT NOT LIMITED TO, COMFORT CARE, HOSPICE CARE, AND PAIN CONTROL.
(2) THE DEPARTMENT SHALL MAKE COPIES OF THE BOOKLET PUBLISHED UNDER SUBSECTION (1) AVAILABLE UPON REQUEST AND WITHOUT CHARGE TO PHYSICIANS WHO ARE SUBJECT TO THIS PART.

SEC. 5683. (1) A DETERMINATION MADE BY AN ATTENDING PHYSICIAN AND VERIFIED BY A CONSULTING PHYSICIAN UNDER THIS PART IN COMBINATION WITH A WRITTEN STATEMENT FROM A PSYCHIATRIST UNDER SECTION 5676(2)(C) CREATES A REBUTTABLE PRESUMPTION THAT THE DETERMINATION IS CORRECT FOR PURPOSES OF A LEGAL PROCEEDING INVOLVING THE PROCEDURES SET FORTH IN THIS PART.

(2) ONLY A SPOUSE OF A PATIENT, A PARENT OF A PATIENT, AN ADULT SIBLING OF A PATIENT, AN ADULT CHILD OF A PATIENT, OR SIGNIFICANT OTHER OF A PATIENT MAY BRING AN ACTION TO CHALLENGE A DETERMINATION MADE IN ACCORDANCE WITH SECTION 5676 OR 5677. IF THE PATIENT IS STILL ALIVE, THE ACTION SHALL BE BROUGHT IN THE CIRCUIT COURT FOR THE COUNTY IN WHICH THE PATIENT RESIDES OR IS FOUND AND ASSIGNED TO THE CHIEF JUDGE OF THAT CIRCUIT.

(3) AS SOON AS PRACTICABLE AFTER AN ACTION DESCRIBED IN SUBSECTION (2) IS FILED, THE CIRCUIT COURT IN WHICH THE ACTION IS FILED SHALL ISSUE A TEMPORARY RESTRAINING ORDER PROHIBITING THE PRESCRIPTION OR DISPENSING, OR BOTH, OF THE REQUESTED MEDICATION OR REQUIRING THE CONFISCATION OF THE REQUESTED MEDICINE. THE ORDER ISSUED UNDER THIS SUBSECTION DOES NOT AFFECT OBTAINING THE DETERMINATIONS MADE BY AN ATTENDING PHYSICIAN, A CONSULTING PHYSICIAN, OR A PSYCHIATRIST UNDER THIS PART.
(4) THE COURT IN WHICH AN ACTION DESCRIBED IN SUBSECTION (2) IS FILED SHALL HOLD AN EXPEDITED HEARING WITHIN 5 DAYS AFTER THE ACTION IS FILED. THE COURT SHALL CONCLUDE THE HEARING WITHIN 2 DAYS AFTER THE HEARING IS COMMENCED AND SHALL RENDER A DECISION IN THE ACTION WITHIN 5 DAYS AFTER THE HEARING IS CONCLUDED.
(5) IF THE CIRCUIT COURT DOES NOT COMPLY WITH THE TIME SCHEDULE PRESCRIBED IN SUBSECTION (4), EITHER PARTY TO THE ACTION MAY SEEK AN EMERGENCY HEARING FOR A SUPERINTENDING CONTROL ORDER FROM THE COURT OF APPEALS TO COMPEL COMPLIANCE BY THE CIRCUIT COURT.

SEC. 5685. (1)THE GOVERNOR SHALL APPOINT AN OVERSIGHT COMMITTEE OF 14 PHYSICIANS AND 3 MEMBERS OF THE GENERAL PUBLIC TO REVIEW THE OPERATION OF THIS PART NOT LATER THAN 90 DAYS AFTER THE EFFECTIVE DATE OF THIS PART AS FOLLOWS:

(A) EIGHT MEMBERS, 2 FROM EACH STATE MEDICAL AND OSTEOPATHIC SCHOOL, SHALL BE APPOINTED FROM NOMINEES SUBMITTED BY THE HIGHEST EXECUTIVE OFFICER OF EACH SCHOOL WHO IS NOT OPPOSED TO COMPLYING WITH THIS PART.
(B) SIX MEMBERS, 3 FROM THE MICHIGAN STATE MEDICAL SOCIETY AND 3 FROM THE MICHIGAN OSTEOPATHIC ASSOCIATION SOCIETY, SHALL BE APPOINTED FROM NOMINEES SUBMITTED BY THE HIGHEST EXECUTIVE OFFICER OF EACH ORGANIZATION WHO IS NOT OPPOSED TO COMPLYING WITH THIS PART.
(C) THREE MEMBERS SHALL BE APPOINTED FROM THE GENERAL PUBLIC. THE MEMBERS APPOINTED UNDER THIS SUBDIVISION SHALL NOT BE OPPOSED TO COMPLYING WITH THIS PART.
(2) EACH NOMINEE UNDER SUBSECTION (1)(A) AND (B) SHALL HAVE PRACTICED HIS OR HER SPECIALTY FOR NOT LESS THAN 10 YEARS. AT LEAST 1 NOMINEE FROM EACH MEDICAL SCHOOL AND PROFESSIONAL ORGANIZATION SHALL BE A SPECIALIST IN ONCOLOGY. A NOMINEE SHALL NOT BE OPPOSED TO COMPLYING WITH THIS PART.
(3) THE GOVERNOR SHALL STAGGER INITIAL APPOINTMENTS FOR TERMS OF UP TO 4 YEARS SO THAT SUBSEQUENT APPOINTMENTS OF 4 YEARS ASSURE CONTINUITY OF EXPERIENCE ON THE OVERSIGHT COMMITTEE.
(4) THE DIRECTOR OF THE DEPARTMENT SHALL SERVE AS EXECUTIVE SECRETARY TO THE OVERSIGHT COMMITTEE, SHALL PROVIDE ALL

NECESSARY ADMINISTRATIVE SUPPORT TO MEMBERS OF THE OVERSIGHT COMMITTEE, AND SHALL OBTAIN PATIENT MEDICAL RECORDS AS DESCRIBED IN THIS SECTION.

(5) NINE MEMBERS CONSTITUTE A QUORUM FOR THE PURPOSE OF CONDUCTING BUSINESS. AS SOON AS 9 MEMBERS ARE APPOINTED, THE OVERSIGHT COMMITTEE IS OPERATIVE.

(6) MEMBERS OF THE OVERSIGHT COMMITTEE SHALL BE COMPENSATED FOR EXPENSES INCURRED IN THE PERFORMANCE OF OFFICIAL DUTIES.

(7) THE OVERSIGHT COMMITTEE SHALL MEET AT LEAST TWICE YEARLY AND, DURING THE COURSE OF THE YEAR, SHALL REVIEW THE PATIENTS' MEDICAL RECORDS OF A RANDOM SAMPLE OF NOT LESS THAN 25% OF ALL DEATHS OCCURRING AS A RESULT OF THE OPERATION OF THIS PART DURING THE PRECEDING YEAR AND SHALL DETERMINE COMPLIANCE BY THE ATTENDING PHYSICIAN, CONSULTING PHYSICIAN, AND PSYCHIATRIST WITH THE REQUIREMENTS OF THIS PART AND WITH THE APPLICABLE STANDARDS OF PRACTICE. THE RANDOM SAMPLE SHALL BE BASED UPON THE PRESCRIPTION COPIES OR INFORMATION SENT TO THE DEPARTMENT UNDER SECTION 5679. AT LEAST 2 MEMBERS OF THE OVERSIGHT COMMITTEE SHALL REVIEW EACH CASE AND PRESENT THEIR FINDINGS TO THE ENTIRE OVERSIGHT COMMITTEE FOR THE OVERSIGHT COMMITTEE'S CONSIDERATION AND DECISION.

(8) IF 25% OF OVERSIGHT COMMITTEE MEMBERS VOTING ON A PARTICULAR CASE DETERMINE THAT A PHYSICIAN HAS NOT COMPLIED WITH THE REQUIREMENTS OF THIS PART OR HAS NEGLIGENTLY FAILED TO COMPLY WITH THE APPLICABLE STANDARDS OF PRACTICE IN PROVIDING THE PROCEDURES AUTHORIZED BY THIS PART, OR BOTH, THE OVERSIGHT COMMITTEE SHALL REVIEW ADDITIONAL MEDICAL RECORDS FROM THE PHYSICIAN OF OTHER PATIENTS, IF ANY, WHOSE DEATHS WERE A RESULT OF THE OPERATION OF THIS PART.

(9) ALL PROCEEDINGS, MINUTES, CONCLUSIONS, AND ACTIONS OF THE OVERSIGHT COMMITTEE AND PATIENT MEDICAL RECORDS AND OTHER MATERIALS REVIEWED BY THE OVERSIGHT COMMITTEE ARE CONFIDENTIAL, ARE NOT PUBLIC RECORDS, ARE NOT OPEN TO INSPECTION, AND ARE NOT SUBJECT TO THE OPEN MEETINGS ACT, 1976 PA 267, MCL 15.261 TO 15.275, OR THE FREEDOM OF INFORMATION ACT, 1976 PA 442, MCL 15.231 TO 15.246. THE OVERSIGHT COMMITTEE SHALL ISSUE AND MAKE AVAILABLE TO THE PUBLIC AN ANNUAL REPORT OF THE EFFECT AND OPERATION OF THIS PART CONTAINING A STATISTICAL SUMMARY, WITHOUT INDIVIDUAL IDENTIFIERS OF PATIENTS OR PHYSICIANS, AND SHALL MAKE AVAILABLE ANY SPECIAL STATISTICAL REPORTS SUBMITTED TO THE GOVERNOR OR LEGISLATURE ON THE OPERATION OF THIS PART, WITHOUT INDIVIDUAL IDENTIFIERS OF PATIENTS OR PHYSICIANS, THAT THE OVERSIGHT COMMITTEE MAY BE REQUIRED TO PREPARE BY THE GOVERNOR OR

LEGISLATURE OR THAT ARE CONSIDERED NECESSARY BY THE OVERSIGHT COMMITTEE.

(10) AN ATTENDING PHYSICIAN, CONSULTING PHYSICIAN, PSYCHIATRIST, PHARMACIST, OR HEALTH FACILITY THAT PARTICIPATES IN THE PROCEDURES AUTHORIZED UNDER THIS PART SHALL MAKE AVAILABLE UPON THE REQUEST OF THE DEPARTMENT PATIENT MEDICAL RECORDS AND ANY OTHER CLINICAL MATERIAL REQUIRED BY THE OVERSIGHT COMMITTEE UNDER THIS SECTION IN A TIMELY FASHION, NOT TO EXCEED 30 DAYS. THE FOLLOWING DO NOT APPLY TO A REQUEST FOR MEDICAL RECORDS, MENTAL HEALTH RECORDS, OR OTHER CLINICAL MATERIAL REQUESTED UNDER THIS SECTION OR TO THE DEPARTMENT ACTING WITHIN THE SCOPE OF ITS AUTHORIZATION:

(A) THE PHYSICIAN-PATIENT PRIVILEGE CREATED IN SECTION 2157 OF THE REVISED JUDICATURE ACT OF 1961, 1961 PA 236, MCL 600.2157.

(B) ANY OTHER HEALTH PROFESSIONAL-PATIENT PRIVILEGE CREATED OR RECOGNIZED BY LAW.

(11) THE DEPARTMENT MAY COMPEL DELIVERY OF THE DOCUMENTS REQUESTED UNDER SUBSECTION (10) BY SUBPOENA, IF THE DOCUMENTS ARE NOT PROVIDED IN A TIMELY FASHION.

(12) ALL PATIENT MEDICAL RECORDS AND OTHER CLINICAL MATERIAL SHALL BE TREATED AS CONFIDENTIAL BY THE OVERSIGHT COMMITTEE, SHALL BE KEPT BY THE DEPARTMENT IN A SECURE AREA, SHALL BE TRANSMITTED TO OVERSIGHT COMMITTEE MEMBERS FOR REVIEW IN A SECURE MANNER, AND SHALL BE RETURNED TO THE HEALTH PROFESSIONAL OR HEALTH FACILITY PROVIDING THE MEDICAL RECORDS AND OTHER CLINICAL MATERIAL AS SOON AS THE OVERSIGHT COMMITTEE HAS NO FURTHER NEED FOR IT.

(13) IF, AS A RESULT OF REVIEWING THE PATIENT MEDICAL RECORDS AND OTHER CLINICAL MATERIAL OF A HEALTH PROFESSIONAL OR HEALTH FACILITY, THE OVERSIGHT COMMITTEE DETERMINES, BY PROCEDURES INCORPORATING APPROPRIATE PROTECTIONS TO BE AGREED UPON BY THE OVERSIGHT COMMITTEE, THAT A HEALTH PROFESSIONAL OR HEALTH FACILITY HAS WILLFULLY FAILED TO COMPLY WITH, OR RECKLESSLY DISREGARDED, THE REQUIREMENTS OF THIS PART, THEN THE OVERSIGHT COMMITTEE SHALL PREPARE A REPORT TO THAT EFFECT AND SUBMIT IT TO THE PROSECUTING ATTORNEY FOR THE COUNTY IN WHICH THE HEALTH PROFESSIONAL PRACTICES OR IN WHICH THE HEALTH FACILITY IS LOCATED.

(14) IF, AFTER REVIEWING PATIENT MEDICAL RECORDS AND OTHER CLINICAL MATERIAL UNDER THIS SECTION, THE OVERSIGHT COMMITTEE DETERMINES BY PROCEDURES INCORPORATING APPROPRIATE PROTECTIONS TO BE AGREED UPON BY THE OVERSIGHT COMMITTEE THAT A PHYSICIAN MAY HAVE NEGLIGENTLY FAILED TO COMPLY WITH THE APPLICABLE STANDARDS OF PRACTICE IN PROVIDING THE PROCEDURES

THE PHYSICIAN IN WRITING OF THAT DETERMINATION AND SHALL PROVIDE THE PHYSICIAN WITH AN OPPORTUNITY FOR A HEARING. THE HEARING SHALL BE CONDUCTED AS A CONTESTED CASE HEARING UNDER THE ADMINISTRATIVE PROCEDURES ACT OF 1969. IF, AFTER NOTICE AND AN OPPORTUNITY FOR A HEARING UNDER THIS SUBSECTION, THE OVERSIGHT COMMITTEE FINDS BY A MAJORITY VOTE THAT THE PHYSICIAN NEGLIGENTLY FAILED TO COMPLY WITH 1 OR MORE APPLICABLE STANDARDS OF PRACTICE IN PROVIDING THE PROCEDURES AUTHORIZED UNDER THIS PART, THE OVERSIGHT COMMITTEE MAY ISSUE AN ORDER LIMITING OR TERMINATING THE PHYSICIAN'S ABILITY TO PRESCRIBE MEDICATION AS AUTHORIZED UNDER THIS PART. AN APPEAL FROM A FINAL ACTION OF THE OVERSIGHT COMMITTEE UNDER THIS SUBSECTION SHALL BE FILED WITH THE CIRCUIT COURT FOR THE COUNTY IN WHICH THE PHYSICIAN HAS HIS OR HER PRIMARY PLACE OF PRACTICE.

(15) IN THE THIRD YEAR AFTER THE EFFECTIVE DATE OF THIS PART AND EVERY 5 YEARS AFTER THAT THIRD YEAR, THE OVERSIGHT COMMITTEE SHALL UNDERTAKE A SURVEY, IN COLLABORATION WITH QUALIFIED EPIDEMIOLOGISTS AT A STATE UNIVERSITY, OF THE EXTENT OF COMPLIANCE WITH THE REPORTING REQUIREMENTS UNDER THIS PART. THE DELIBERATIONS AND PROCEEDINGS OF THE OVERSIGHT COMMITTEE AND THE EPIDEMIOLOGISTS UNDER THIS SUBSECTION ARE NOT SUBJECT TO THE OPEN MEETINGS ACT, 1976 PA 267, MCL 15.261 TO 15.275. INFORMATION COLLECTED IN THE COURSE OF THE INVESTIGATION IS NOT A PUBLIC RECORD, SHALL NOT BE MADE AVAILABLE FOR INSPECTION BY THE PUBLIC, AND IS EXEMPT FROM DISCLOSURE UNDER THE FREEDOM OF INFORMATION ACT, 1976 PA 442, MCL 15.231 TO 15.246. THE OVERSIGHT COMMITTEE SHALL MAKE AVAILABLE TO THE PUBLIC A REPORT OF THIS INVESTIGATION CONTAINING A STATISTICAL SUMMARY, WITHOUT INDIVIDUAL IDENTIFIERS OF PATIENTS OR PHYSICIANS.

(16) ALL INFORMATION ACQUIRED UNDER SUBSECTION (15) SHALL BE TREATED AS CONFIDENTIAL BY SURVEY PERSONNEL, SHALL BE KEPT BY THE DIRECTOR OF THE SURVEY IN A SECURE AREA, AND SHALL BE DESTROYED ONCE THE REPORT IS COMPLETE.

(17) THE GOVERNOR'S FAILURE TO APPOINT OVERSIGHT COMMITTEE MEMBERS DOES NOT ALTER THE EFFECTIVE DATE OF THIS PART.

SEC. 5686. (1) PURSUANT TO SECTION 2844, THE DEATH OF A PATIENT WHO ENDS HIS OR HER LIFE AFTER COMPLYING WITH THIS PART SHALL BE CLASSIFIED FOR LEGAL PURPOSES AS HAVING BEEN CAUSED BY THE PATIENT'S TERMINAL ILLNESS.

(2) A PATIENT WHO ENDS HIS OR HER LIFE IN COMPLIANCE WITH THIS PART SHALL NOT BE CONSIDERED A SUICIDE OR AN INTENTIONAL DEATH FOR

THE PURPOSE OF VOIDING A POLICY OF INSURANCE ON THE LIFE OF THE PATIENT.
(3) A PROVISION IN A CONTRACT, WILL, OR OTHER AGREEMENT, WHETHER WRITTEN OR ORAL, IS INVALID TO THE EXTENT THE PROVISION WOULD AFFECT WHETHER AN INDIVIDUAL MAY MAKE OR RESCIND A REQUEST UNDER THIS PART, OR USE MEDICATION PRESCRIBED UNDER THIS PART, TO END HIS OR HER LIFE.
(4) THE MAKING OR RESCINDING OF A REQUEST UNDER THIS PART OR THE USE OF MEDICATION PRESCRIBED UNDER THIS PART SHALL NEITHER AFFECT NOR BE A CONDITION UPON AN OBLIGATION OWING UNDER A PRESENTLY EXISTING CONTRACT, OR THE SALE, PROCUREMENT, COVERAGE, BENEFITS, OR ISSUANCE OF A LIFE, HEALTH, ACCIDENT, OR ANNUITY POLICY, OR THE RATE CHARGED FOR SUCH A POLICY.

SEC. 5687. (1) BEGINNING 2 YEARS AFTER THE EFFECTIVE DATE OF THIS PART, A PHYSICIAN WHO PROVIDES PATIENTS WITH THE PROCEDURES AUTHORIZED BY THIS PART WHO APPLIES FOR RENEWAL OF HIS OR HER LICENSE SHALL PRESENT SATISFACTORY EVIDENCE, AS PART OF THE 150 HOURS OF CONTINUING MEDICAL EDUCATION REQUIRED UNDER SECTIONS 17033 AND 17533, REGARDLESS OF ANY PREVIOUS TRAINING, THAT HE OR SHE HAS HAD NOT LESS THAN 20 HOURS OF CONTINUING MEDICAL EDUCATION IN THE THEORY AND PRACTICE OF COMFORT CARE, HOSPICE CARE, PAIN CONTROL, SEDATION COMA, REMOVAL OF NUTRITION AND HYDRATION, PSYCHIATRIC COUNSELING, AND THE PRESCRIPTION OF MEDICATIONS AUTHORIZED BY THIS PART.

(2) AT A LICENSE RENEWAL SUBSEQUENT TO THE LICENSE RENEWAL DESCRIBED IN SUBSECTION (1), A PHYSICIAN SHALL PRESENT TO THE BOARD SATISFACTORY EVIDENCE, AS PART OF THE 150 HOURS OF CONTINUING MEDICAL EDUCATION REQUIRED UNDER SECTIONS 17033 AND 17533, OF 4 HOURS OF THE CONTINUING MEDICAL EDUCATION DESCRIBED IN SUBSECTION (1).

SEC. 5688. (1) EXCEPT AS OTHERWISE PROVIDED IN THIS PART, A HEALTH CARE PROVIDER OR OTHER PERSON IS NOT SUBJECT TO CIVIL OR CRIMINAL LIABILITY OR ADMINISTRATIVE DISCIPLINARY ACTION FOR PARTICIPATING IN THE PROCEDURES AUTHORIZED BY THIS PART IN GOOD FAITH AND IN COMPLIANCE WITH THIS PART OR FOR NOT PARTICIPATING IN THOSE PROCEDURES. IN ADDITION, A HEALTH CARE PROVIDER WHO CLAIMS THE IMMUNITY PROVIDED BY THIS SUBSECTION MUST HAVE CONFORMED HIS OR HER OR THE HEALTH FACILITY’S CONDUCT UNDER THIS PART TO THE APPLICABLE STANDARD OF PRACTICE FOR THE CONDUCT, PROCEDURES, OR DETERMINATIONS UNDERTAKEN UNDER THIS PART.

(2) THIS PART DOES NOT PROVIDE FOR OR OTHERWISE ALLOW A LOWER

STANDARD OF PRACTICE OR CARE FOR PATIENTS WITH TERMINAL ILLNESS.
(3) A PROFESSIONAL ORGANIZATION OR ASSOCIATION OR A HEALTH FACILITY OR OTHER HEALTH CARE PROVIDER SHALL NOT SUBJECT A PERSON TO CENSURE, DISCIPLINE, SUSPENSION, LOSS OF LICENSE, LOSS OF PRIVILEGES, LOSS OF MEMBERSHIP, OR OTHER PENALTY FOR PARTICIPATING OR REFUSING TO PARTICIPATE IN THE PROCEDURES AUTHORIZED BY THIS PART.
(4) PROVISION BY AN ATTENDING PHYSICIAN OF MEDICATION IN COMPLIANCE WITH THIS PART DOES NOT CONSTITUTE NEGLIGENCE OR MALPRACTICE FOR ANY PURPOSE OF LAW.
(5) A REQUEST BY A PATIENT IN COMPLIANCE WITH THIS PART DOES NOT PROVIDE THE SOLE BASIS FOR THE APPOINTMENT OF A GUARDIAN OR CONSERVATOR.
(6) A HEALTH FACILITY MAY PROHIBIT THE PROCEDURES AUTHORIZED BY THIS PART AND IMPOSE 1 OR MORE OF THE SANCTIONS DESCRIBED IN SUBSECTION (3), IF ALL OF THE FOLLOWING REQUIREMENTS ARE MET:
(A) THE HEALTH FACILITY HAS GIVEN REASONABLE NOTICE OF THE PROHIBITION TO ITS STAFF AND TO THE PUBLIC.

(B) IF REQUESTED BY A PATIENT, THE HEALTH FACILITY PROVIDES A TRANSFER OF THE PATIENT WITHIN 48 HOURS TO ANOTHER HEALTH FACILITY OF THE PATIENT’S CHOICE THAT WILL ALLOW THE PROCEDURES AUTHORIZED BY THIS PART, ALONG WITH A COPY OF THE PATIENT’S RELEVANT MEDICAL RECORDS AT THE TIME OF TRANSFER.

(C) THE PARTICIPATION OF HEALTH FACILITY STAFF IN THE PROCEDURES AUTHORIZED BY THIS PART OUTSIDE THE HEALTH FACILITY IS NOT CONSIDERED A VIOLATION OF THE PROHIBITION.

SEC. 5689. (1) A NON-PHYSICIAN OR UNLICENSED PHYSICIAN WHO ADMINISTERS, CAUSES TO BE ADMINISTERED, DELIVERS, OR CAUSES TO BE DELIVERED MEDICATIONS, CHEMICALS, OR ANY OTHER INSTRUMENTALITY, OR THE APPARATUS FOR THEIR DELIVERY OR USE, TO AN INDIVIDUAL FOR USE IN A MANNER SUBSTANTIALLY LIKELY TO CAUSE OR HASTEN THAT INDIVIDUAL’S DEATH, IS GUILTY OF A FELONY PUNISHABLE BY IMPRISONMENT FOR A TERM OF YEARS UP TO LIFE, REGARDLESS OF WHETHER OR NOT THE PURPOSE IS TO RELIEVE PAIN OR SUFFERING.

(2) ONCE MEDICATION HAS BEEN PRESCRIBED UNDER SECTION 5679, SUBSECTION (1) DOES NOT APPLY TO A NON-PHYSICIAN HEALTH CARE PROVIDER, TO AN EMPLOYEE OF A HEALTH FACILITY, OR TO A PATIENT’S FAMILY MEMBER OR FRIEND WHO, AT THE PATIENT’S REQUEST, FILLS OR DELIVERS TO THE PATIENT THE PRESCRIPTION OR WHO, AT THE PATIENT’S REQUEST, SUPPORTS, CRADLES, OR MAKES THE PATIENT COMFORTABLE WHILE THE PATIENT SELF-ADMINISTERS THE PRESCRIBED MEDICATION.

(3) A PERSON WHO, WITHOUT AUTHORIZATION OF THE PATIENT, WILLFULLY ALTERS OR FORGES A REQUEST FOR MEDICATION UNDER THIS PART OR CONCEALS OR DESTROYS A RESCISSION OF THAT REQUEST WITH THE INTENT OR EFFECT OF CAUSING THE PATIENT'S DEATH IS GUILTY OF A FELONY PUNISHABLE BY IMPRISONMENT FOR A TERM OF YEARS UP TO LIFE.

(4) A PERSON WHO COERCES OR EXERTS UNDUE INFLUENCE ON A PATIENT TO MAKE A REQUEST UNDER THIS PART, OR TO DESTROY A RESCISSION OF A REQUEST, IS GUILTY OF A FELONY PUNISHABLE FOR A TERM OF YEARS UP TO LIFE.

(5) A PHYSICIAN WHO WILLFULLY, OR WITH RECKLESS DISREGARD, FAILS TO COMPLY WITH THE REQUIREMENTS OF THIS PART AND WHO, AT THE REQUEST OF A PERSON UNDER THE PHYSICIAN'S CARE, PROVIDES TO THAT PERSON MEDICATION OR OTHER INSTRUMENTALITY FOR SELF-ADMINISTRATION THAT IS INTENDED TO CAUSE OR HASTEN DEATH IS GUILTY OF A FELONY PUNISHABLE BY A FINE OF NOT MORE THAN $50,000.00 OR IMPRISONMENT FOR UP TO 5 YEARS, OR BOTH.

(6) A PHYSICIAN WHO WILLFULLY FAILS TO COMPLY WITH SECTION 5678 OR 5681(2) IS GUILTY OF A MISDEMEANOR PUNISHABLE BY A FINE OF NOT MORE THAN $10,000.00 OR IMPRISONMENT FOR UP TO 90 DAYS, OR BOTH.
(7) A PERSON WHO FILES A FALSE AFFIDAVIT OF RELATION TO A RESIDENT, AS DESCRIBED IN SECTION 5673(Q), IS GUILTY OF A MISDEMEANOR PUNISHABLE BY A FINE OF NOT MORE THAN $10,000.00 OR IMPRISONMENT FOR NOT MORE THAN 90 DAYS, OR BOTH.
(8) A PHARMACIST WHO FAILS TO FORWARD PRESCRIPTION INFORMATION OR A COPY OF THE PRESCRIPTION PROVIDED TO A PATIENT AS REQUIRED BY SECTION 5679(3) IS GUILTY OF A MISDEMEANOR PUNISHABLE BY A FINE OF NOT MORE THAN $1,000.00.
(9) THE PENALTIES IMPOSED BY THIS SECTION DO NOT PRECLUDE CRIMINAL PENALTIES APPLICABLE UNDER OTHER STATUTES, INCLUDING CRIMINAL ATTEMPTS PURSUANT TO SECTION 29 OF THE MICHIGAN PENAL CODE, 1931 PA 328, MCL 750.29.
(10) THIS SECTION DOES NOT LIMIT LIABILITY FOR CIVIL DAMAGES RESULTING FROM OTHER NEGLIGENT OR WILLFUL CONDUCT.

SEC. 5690. (1) THE DEPARTMENT MAY PROMULGATE RULES TO IMPLEMENT THIS PART.

(2) IN THE CONDUCT OF THE REVIEW AND INVESTIGATIVE FUNCTIONS OF THE OVERSIGHT COMMITTEE ESTABLISHED UNDER SECTION 5685, THE DEPARTMENT MAY REQUIRE BY SUBPOENA THE ATTENDANCE AND TESTIMONY UNDER OATH OF WITNESSES AND THE PRODUCTION OF EVIDENCE, INCLUDING MEDICAL RECORDS AND OTHER CLINICAL

MATERIAL. WITNESSES SHALL BE PAID THE SAME FEES AND MILEAGE THAT ARE PAID WITNESSES IN THE CIRCUIT COURTS. IN CASE OF A FAILURE OR A REFUSAL OF A PERSON TO OBEY A SUBPOENA ISSUED BY THE DEPARTMENT, THE CIRCUIT COURT FOR THE COUNTY OF INGHAM, UPON APPLICATION BY THE DIRECTOR OF THE DEPARTMENT, MAY ISSUE AN ORDER REQUIRING THE PERSON TO APPEAR AND PRODUCE EVIDENCE OR GIVE TESTIMONY AS MAY BE REQUIRED FOR THE OVERSIGHT COMMITTEE FUNCTION. FAILURE TO OBEY THE ORDER OF THE CIRCUIT COURT MAY BE PUNISHED AS CONTEMPT.
(3) A PERSON WHO WILLFULLY FAILS TO COMPLY WITH A SUBPOENA ISSUED UNDER THIS SECTION IS SUBJECT TO A FINE OF NOT MORE THAN $2,000.00 FOR EACH VIOLATION OR DAY THAT A VIOLATION CONTINUES.

SEC.5691. IF ANY PORTION OF THE AMENDATORY ACT THAT ADDED THIS PART OR THE APPLICATION OF THIS PART TO ANY PERSON OR CIRCUMSTANCE IS FOUND TO BE INVALID BY A COURT, THE INVALIDITY DOES NOT AFFECT THE REMAINING PORTIONS OR APPLICATIONS OF THIS PART THAT CAN BE GIVEN EFFECT WITHOUT THE INVALID PORTION OR APPLICATION, IF REMAINING PORTIONS OF THE AMENDATORY ACT THAT ADDED THIS PART ARE NOT DETERMINED BY THE COURT TO BE INOPERABLE, AND TO THIS END THE AMENDATORY ACT THAT ADDED THIS PART IS DECLARED TO BE SEVERABLE.

Sec. 7401. (1) Except as authorized by this article, a person shall not manufacture, create, deliver, or possess with intent to manufacture, create, or deliver a controlled substance, a prescription form, an official prescription form, or a counterfeit prescription form. A practitioner licensed by the administrator under this article shall not dispense, prescribe, or administer a controlled substance for other than legitimate and professionally recognized therapeutic or scientific purposes or outside the scope of practice of the practitioner, licensee, or applicant. THE DISPENSING, PRESCRIPTION, OR ADMINISTRATION OF A CONTROLLED SUBSTANCE FOR USE IN THE PROCEDURES AUTHORIZED UNDER PART 56B IS NOT A VIOLATION OF THIS SUBSECTION.

(2) A person who violates this section as to:
(a) A controlled substance classified in schedule 1 or 2 that is a narcotic drug or a drug described in section 7214(a)(iv) and:

(i) Which is in an amount of 650 grams or more of any mixture containing that substance is guilty of a felony and shall be imprisoned for life except as otherwise provided in this subparagraph. A person convicted of violating this subparagraph may be punished as provided by law by imposing a sentence of imprisonment for any term of years but not less than 25 years if any of the following apply:
(A) The person is within the jurisdiction of the circuit court [*or recorder's court of the City of Detroit*] under section 606 of the revised judicature act of 1961, [*Act No. 236 of the Public Acts of 1961, being section 600.606 of the Michigan compiled laws*]1961 PA 236,

being section 712A.4 of the Michigan Compiled Laws, or section 10A(1)(c) of Act No. 369 of the Public Acts of 1919, being section 725.10A of the Michigan Compiled Laws]1939 PA 288, MCL 712A.4.
(B) The person is being sentenced under section 18(1)(n) of chapter XIIA of [*Act No. 288 of the Public Acts of 1939, being section 712A.18 of the Michigan Compiled Laws*]1939 PA 288, MCL 712A.18.
(ii) Which is an amount of 225 grams or more, but less than 650 grams, of any mixture containing that substance is guilty of a felony and shall be imprisoned for not less than 20 years nor more than 30 years.
(iii) Which is in an amount of 50 grams or more, but less than 225 grams, of any mixture containing that substance is guilty of a felony and shall be imprisoned for not less than 10 years nor more than 20 years.
(iv) Which is in an amount less than 50 grams, of any mixture containing that substance is guilty of a felony and shall be imprisoned for not less than 1 year nor more than 20 years, and may be fined not more than $25,000.00, or placed on probation for life.

(b) Any other controlled substance classified in schedule 1, 2, or 3, except marihuana, is guilty of a felony punishable by imprisonment for not more than 7 years or a fine of not more than $10,000.00, or both.
(c) A substance classified in schedule 4, is guilty of a felony punishable by imprisonment for not more than 4 years or a fine of not more than $2,000.00, or both.
(d) Marihuana or a mixture containing marihuana, is guilty of a felony punishable as follows:
(i) If the amount is 45 kilograms or more, or 200 plants or more by imprisonment for not more than 15 years or a fine of not more than $10,000,000.00, or both.
(ii) If the amount is 5 kilograms or more but less than 45 kilograms, or 20 plants or more but fewer than 200 plants, by imprisonment for not more than 7 years or a fine of not more than $500,000.00, or both.
(iii) If the amount is less than 5 kilograms or fewer than 20 plants, by imprisonment for not more than 4 years or a fine of not more than $20,000.00, or both.
(e) A substance classified in schedule 5, is guilty of a felony punishable by imprisonment for not more than 2 years or a fine of not more than $2,000.00, or both.
(f) An official prescription form or a counterfeit official prescription form, is guilty of a felony punishable by imprisonment for not more than 20 years or a fine of not more than $25,000.00, or both.
(g) A prescription form or a counterfeit prescription form other than an official prescription form or a counterfeit official prescription form, is guilty of a felony punishable by imprisonment for not more than 7 years or a fine of not more than $5,000.00, or both.
(3) A term of imprisonment imposed pursuant to subsection (2)(a) or section 7403(2)(a)*(i), (ii), (iii),* or *(iv)* shall be imposed to run consecutively with any term of imprisonment imposed for the commission of another felony. An individual subject to a mandatory term of imprisonment under subsection (2)(a) or section 7403(2)(a)*(i), (ii), (iii)*, or *(iv)* shall not be eligible for probation, suspension of that sentence, or parole during that mandatory term, except and only to the extent that those provisions permit probation for life, and shall not receive a reduction in that mandatory term of imprisonment by disciplinary credits or any

other type of sentence credit reduction.
(4) The court may depart from the minimum term of imprisonment authorized under subsection (2)(a)*(ii), (iii),* or *(iv)* if the court finds on the record that there are substantial and compelling reasons to do so. In addition, if any of the following apply, the court may depart from the minimum term of imprisonment authorized under subsection (2)(a)*(ii), (iii),* or *(iv)* if the individual has not previously been convicted of a felony or an assaultive crime and has not been convicted of another felony or assaultive crime arising from the same transaction as the violation of this section:

(a) The person is within the jurisdiction of the circuit court [*or recorder's court of the city of Detroit*]under section 606 of the revised judicature act of 1961, [*Act No. 236 of the Public Acts of 1961, being section 600.606 of the Michigan Compiled Laws*] 1961 PA 236, MCL 600.606, OR section 4 of chapter XIIA of [*Act No 288 of the Public Acts of 1939, being section 712A.4 of the Michigan Compiled Laws, or section 10a(1)(c) of Act No 369 of the Public Acts of 1919, being section 725.10a of the Michigan Compiled Laws]* 1939 PA 288, MCL 712A.4.

(b) The person is being sentenced under section 18(1)(n) of chapter XIIA of [*Act No. 288 of the Public Acts of 1939, being section 712A.18 of the Michigan Compiled Laws*] 1939 PA 288 MCL 712A.18.
(5) As used in this section:
(a) "Assaultive crime" means a violation of chapter XI of the Michigan penal code, [*Act No. 328 of the Public Acts of 1931, being section 750 81 to 570.90 of the Michigan Compiled Laws*] 1931 PA 328, MCL 750.81 TO 750.90.
(b) "Plant" means a marihuana plant that has produced cotyledons or a cutting of a marihuana plant that has produced cotyledons.

Sec. 16221. The department may investigate activities related to the practice of a health profession by a licensee, a registrant, or an applicant for licensure or registration. The department may hold hearings, administer oaths, and order relevant testimony to be taken and shall report its findings to the appropriate disciplinary subcommittee. The disciplinary subcommittee shall proceed under section 16226 if it finds that 1 or more of the following grounds exist:

(a) A violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition which impairs, or may impair, the ability to safely and skillfully practice the health profession.
(b) Personal disqualifications, consisting of 1 or more of the following:

(i) Incompetence.
(ii) Subject to sections 16165 to 16170a, substance abuse as defined in section 6107.
(iii) Mental or physical inability reasonably related to and adversely affecting the licensee's ability to practice in a safe and competent manner.

(v) Conviction of a misdemeanor punishable by imprisonment for a maximum term of 2 years; a misdemeanor involving the illegal delivery, possession, or use of a controlled substance; or a felony. A certified copy of the court record is conclusive evidence of the conviction.
(vi) Lack of good moral character.
(vii) Conviction of a criminal offense under sections 520a to 520l of the Michigan penal code, *[Act No 328 of the Public Acts of 1931, being sections 750.520a to 750.520l, of the Michigan Compiled Laws*] 1931 PA 328, MCL 750.520A TO 750.520l . A certified copy of the court record is conclusive evidence of the conviction.
(viii) Conviction of a violation of section 492a of the Michigan penal code, *[Act No. 328 of the Public Acts of 1931, being section 750.492a of the Michigan Compiled Laws*] 1931 PA 328, MCL 750.492A. A certified copy of the court record is conclusive evidence of the conviction.
(ix) Conviction of a misdemeanor or felony involving fraud in obtaining or attempting to obtain fees related to the practice 25 of a health profession. A certified copy of the court record is 26 conclusive evidence of the conviction.
(x) Final adverse administrative action by a licensure, registration, disciplinary, or certification board involving the holder of, or an applicant for, a license or registration regulated by another state or a territory of the United States. A certified copy of the record of the board is conclusive evidence of the final action.
(xi) Conviction of a misdemeanor that is reasonably related to or that adversely affects the licensee's ability to practice in a safe and competent manner. A certified copy of the court record is conclusive evidence of the conviction.

(c) Prohibited acts, consisting of 1 or more of the following:
(i) Fraud or deceit in obtaining or renewing a license or registration.
(ii) Permitting the license or registration to be used by an unauthorized person.
(iii) Practice outside the scope of a license.
(iv) Obtaining, possessing, or attempting to obtain or possess a controlled substance as defined in section 7104 or a drug as defined in section 7105 without lawful authority; or selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes. THE PROVISION OF DRUGS TO COMPLY WITH A REQUEST MADE IN COMPLIANCE WITH PART 56B IS NOT A PROHIBITED ACT.
(d) Unethical business practices, consisting of 1 or more of the following:
(i) False or misleading advertising.
*(ii)*Dividing fees for referral of patients or accepting kickbacks on medical or surgical services, appliances, or medications purchased by or in behalf of patients.
(iii) Fraud or deceit in obtaining or attempting to obtain third party reimbursement.
(e) Unprofessional conduct, consisting of 1 or more of the following:
(i) Misrepresentation to a consumer or patient or in obtaining or attempting to obtain third party reimbursement in the course of professional practice.
(ii) Betrayal of a professional confidence.

(iii) Promotion for personal gain of an unnecessary drug, device, treatment, procedure, or service.

(iv) Directing or requiring an individual to purchase or secure a drug, device, treatment, procedure, or service from another person, place, facility, or business in which the licensee has a financial interest.

(f) Failure to report a change of name or mailing address within 30 days after the change occurs.

(g) A violation, or aiding or abetting in a violation, of this article or of a rule promulgated under this article.

(h) Failure to comply with a subpoena issued pursuant to this part, failure to respond to a complaint issued under this article or article 7, failure to appear at a compliance conference or an administrative hearing, or failure to report under section 16222 or 16223.

(i) Failure to pay an installment of an assessment levied pursuant to section 2504 of the insurance code of 1956, Act [*No 218 of the Public Acts of 1956, being section 500.2504 of the Michigan Compiled Laws 1956]* PA 218, MCL 500.2504, within 60 days after notice by the appropriate board.

(j) A violation of section 17013 or 17513.

(k) Failure to meet 1 or more of the requirements for licensure or registration under section 16174.

(l) A violation of section 17015 or 17515.

(m) A violation of section 17016 or 17516.

(n) A violation of section 5654 or 5655.

(o)A VIOLATION OF SECTION 5676 OR 5679.

Sec. 16226. (1) After finding the existence of 1 or more of the grounds for disciplinary subcommittee action listed in section 16221, a disciplinary subcommittee shall impose 1 or more of the following sanctions for each violation:

Violations of Section 16221	**Sanctions**
Subdivision (a), (b)*(ii),* (b)*(iv)*, or (b)*(vii)*	Probation, limitation, denial, suspension, revocation, restitution, community service, fine.
Subdivision (b)*(viii)*	Revocation or denial.
Subdivision (b)*(i),* (b)*(iii)*, (b)*(v)*, (b)*(ix*), (b)(*x*), or (b)(*xi*)	Limitation, suspension, revocation, denial, probation, restitution, community service, fine.
Subdivision (c)*(i)*	Denial, revocation, suspension, probation, limitation, community service, or fine.

Subdivision (c)*(ii)*	Denial, suspension, revocation, restitution, community service, or fine.
Subdivision (c)*(iii)*	Probation, denial, suspension, revocation, restitution, community service, or fine.
Subdivision (c)*(iv)* or (d)*(iii)*	Fine, probation, denial, suspension, revocation, community service, or restitution.
Subdivision (d)(*i)* or (d)*(ii)*	Reprimand, fine, probation, community service, denial, or restitution.
Subdivision (e)*(i)*	Reprimand, fine, probation, limitation, suspension, community service, denial, or restitution.
Subdivision (e)*(ii)* or (h)	Reprimand, probation, suspension, restitution, community service, denial, or fine.
Subdivision (e)*(iii)* or (e)*(iv)*	Reprimand, fine, probation, suspension, revocation, limitation, community service, denial, or restitution.
Subdivision (f)	Reprimand or fine.
Subdivision (g)	Reprimand, probation, denial, suspension, revocation, limitation, restitution, community service, or fine.
Subdivision (i)	Suspension or fine.
Subdivision (j) or (n)	Reprimand or fine.
Subdivision (k)	Reprimand, denial, or limitation.

Subdivision (l) OR (O)	Denial, revocation, restitution, probation, suspension, limitation, reprimand, or fine.
Subdivision (m)	Revocation or denial.

(2) Determination of sanctions for violations under this section shall be made by a disciplinary subcommittee. If, during judicial review, the court of appeals determines that a final decision or order of a disciplinary subcommittee prejudices substantial rights of the petitioner for 1 or more of the grounds listed in section 106 of the administrative procedures act of 1969, [*being section 24.306 of Michigan Compiled Laws]* 1969 PA 306, MCL 24.306, and holds that the final decision or order is unlawful and is to be set aside, the court shall state on the record the reasons for the holding and may remand the case to the disciplinary subcommittee for further consideration.

(3) A disciplinary subcommittee may impose a fine of up to, but not exceeding, $250,000.00 for a violation of section 16221(a) or (b).

(4) A disciplinary subcommittee may require a licensee or registrant or an applicant for licensure or registration who has violated this article or article 7 or a rule promulgated under this article or article 7 to satisfactorily complete an educational program, a training program, or a treatment program, a mental, physical, or professional competence examination, or a combination of those programs and examinations.

Sec. 17033. (1) Notwithstanding the requirements of part 161 AND SUBJECT TO SUBSECTIONS (2) AND (3), the board may require a licensee seeking renewal of a license to furnish the board with satisfactory evidence that during the 3 years immediately preceding application for renewal the licensee has attended continuing education courses or programs approved by the board totaling not less than 150 hours in subjects related to the practice of medicine including, but not limited to, medical ethics and designed to further educate licensees.

(2) As required under section 16204, the board shall promulgate rules requiring each applicant for license renewal to complete as part of the continuing education requirement of subsection (1) an appropriate number of hours or courses in pain and symptom management.

(3) PURSUANT TO SECTION 5687 AND AS PART OF THE CONTINUING EDUCATION REQUIREMENT OF SUBSECTION (1), BEGINNING 2 YEARS AFTER THE EFFECTIVE DATE OF PART 56B, A PHYSICIAN WHO PROVIDES PATIENTS WITH THE PROCEDURES AUTHORIZED BY PART 56B AND WHO APPLIES FOR RENEWAL OF HIS OR HER LICENSE SHALL PRESENT SATISFACTORY EVIDENCE, REGARDLESS OF ANY PREVIOUS TRAINING, THAT HE OR SHE HAS HAD NOT LESS THAN 20 HOURS OF CONTINUING MEDICAL EDUCATION IN THE THEORY AND PRACTICE OF COMFORT CARE, HOSPICE CARE, PAIN CONTROL, SEDATION COMA, REMOVAL OF NUTRITION AND HYDRATION, PSYCHIATRIC COUNSELING, AND THE PRESCRIPTION OF MEDICATIONS AUTHORIZED BY PART 56B. AT SUBSEQUENT RENEWALS, 4 HOURS OF SUCH TRAINING MUST BE DOCUMENTED.

Sec. 17533. (1) Notwithstanding the requirements of part 161AND SUBJECT TO SUBSECTIONS (2) AND (3), the board may require a licensee seeking renewal of a license to furnish the board with satisfactory evidence that during the 3 years immediately preceding an application for renewal the licensee has attended continuing education courses or programs approved by the board and totaling no less than 150 hours in subjects related to the practice of osteopathic medicine and surgery and designed to further educate licensees.

(2) As required under section 16204, the board shall promulgate rules requiring each applicant for license renewal to complete as part of the continuing education requirement of subsection (1) an appropriate number of hours or courses in pain and symptom management.
(3) PURSUANT TO SECTION 5687 AND AS PART OF THE CONTINUING EDUCATION REQUIREMENT OF SUBSECTION (1), BEGINNING 2 YEARS AFTER THE EFFECTIVE DATE OF PART 56B, A PHYSICIAN WHO PROVIDES PATIENTS WITH THE PROCEDURES AUTHORIZED BY PART 56B AND WHO APPLIES FOR RENEWAL OF HIS OR HER LICENSE SHALL PRESENT SATISFACTORY EVIDENCE, REGARDLESS OF ANY PREVIOUS TRAINING, THAT HE OR SHE HAS HAD NOT LESS THAN 20 HOURS OF CONTINUING MEDICAL EDUCATION IN THE THEORY AND PRACTICE OF COMFORT CARE, HOSPICE CARE, PAIN CONTROL, SEDATION COMA, REMOVAL OF NUTRITION AND HYDRATION, PSYCHIATRIC COUNSELING, AND PRESCRIPTION OF MEDICATIONS AUTHORIZED BY PART 56B. AT SUBSEQUENT RENEWALS, 4 HOURS OF SUCH TRAINING MUST BE DOCUMENTED.

Sec. 17766. Except as provided in section 17766a, a person who does [*any*] 1 OR MORE of the following is guilty of a misdemeanor:

(a) Obtains or attempts to obtain a prescription drug by giving a false name to a pharmacist or other authorized seller, prescriber, or dispenser.
(b) Obtains or attempts to obtain a prescription drug by falsely representing that he or she is a lawful prescriber, dispenser, or licensee, or acting on behalf of a lawful prescriber, dispenser, or licensee.
(c) Falsely makes, utters, publishes, passes, alters, or forges a prescription.
(d) Knowingly possesses a false, forged, or altered prescription.
(e) Knowingly attempts to obtain, obtains, or possesses a drug by means of a prescription for other than a legitimate therapeutic purpose, or as a result of a false, forged, or altered prescription. THE PRESCRIPTION, OBTAINING, ATTEMPTING TO OBTAIN, AND POSSESSION OF A DRUG FOR USE IN THE PROCEDURES AUTHORIZED UNDER PART 56B IS NOT A VIOLATION OF THIS SUBDIVISION.
(f) Possesses or controls for the purpose of resale, or sells, offers to sell, dispenses, or gives away, a drug, pharmaceutical preparation, or chemical that has been dispensed on prescription and has left the control of a pharmacist, or that has been damaged by heat, smoke, fire, water, or other cause and is unfit for human or animal use.
(g) Prepares or permits the preparation of a prescription drug, except as delegated by a pharmacist.

(h) Sells a drug in bulk or in an open package at auction, unless the sale has been approved in accordance with rules of the board.

Sec. 20165. (1) Except as otherwise provided in this section, after notice of intent to an applicant or licensee to deny, limit, suspend, or revoke a license or certification and an opportunity for a hearing, the department may deny, limit, suspend, or revoke the license or certification if any 1 OR MORE of the following exist:

(a) Fraud or deceit in obtaining or attempting to obtain a license or certification or in operation of the licensed health facility or agency.
(b) A violation of this article or the rules promulgated under this article.
(c) False or misleading advertising.
(d) Negligence or failure to exercise due care, including negligent supervision of employees and subordinates.
(e) Permitting a license or certificate to be used by an unauthorized health facility or agency.
(f) Evidence of abuse regarding patient health, welfare, or safety or a denial of rights.
(g) Failure to comply with section 10102a(7).
(h) Failure to comply with part 222 or a term, condition, or stipulation of a certificate of need issued under part 222, or both.
(i) FAILURE TO COMPLY WITH SECTION 5688 OR ANOTHER APPLICABLE PROVISION OF PART 56B.
(2) An application for a license or certification may be denied on a finding of any condition or practice which would constitute a violation of this article if the applicant were a licensee.
(3) Denial, suspension, or revocation of an individual emergency medical services personnel license under part 209 is governed by section 20958.

Enacting section 1.

1992 PA 270, MCL 752.1021 to 752.1027, is repealed.

"Medical examiner act" Sec. 2.

(1)[*County*] EXCEPT AS OTHERWISE PROVIDED IN SUBSECTION (2), A COUNTY medical [*examiners*] EXAMINER or deputy county medical [*examiners*] EXAMINER shall [*make investigations as to*] INVESTIGATE the cause and manner of death in [*all]* EACH OF THE FOLLOWING cases: [o*f persons who have come to their death]*
(A) THE CASE OF A PERSON WHO HAD DIED by violence. [*; or*]
(B) THE CASE OF A PERSON whose death was unexpected. [*; or*]
(C) THE CASE OF A PERSON WHO HAS DIED without medical attendance during the 48 hours [*prior to*] IMMEDIATELY PRECEDING the hour of death, unless the attending physician, if any, is able to determine accurately the cause of death. [*; or*]
(D) THE CASE OF A PERSON WHO HAS DIED as the result of an abortion, whether self-induced or otherwise.
(2) A COUNTY MEDICAL EXAMINER OR DEPUTY COUNTY MEDICAL EXAMINER SHALL NOT INVESTIGATE THE DEATH OF A PERSON WHO HAS

DIED AS A RESULT OF THE PROCEDURES AUTHORIZED UNDER PART 56B OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.5671 TO 333.5691, UNLESS THE COUNTY MEDICAL EXAMINER OR DEPUTY COUNTY MEDICAL EXAMINER IS REQUIRED TO INVESTIGATE THE DEATH UNDER THE CIRCUMSTANCES DESCRIBED IN SUBSECTION (1)(A).
(3) If [*any*] A prisoner in [*any*] A county or city jail dies while imprisoned, the county medical examiner, upon being notified of the death of the prisoner, shall [*make an examination upon*] EXAMINE the body of the deceased prisoner.

Sec. 3. [*Any physician and any*] A PHYSICIAN, A person in charge of [*any*] A hospital or institution, or [*any*] A person who [*shall have]* HAS first knowledge of the death of [*any*] A person who [*shall have]* died suddenly, unexpectedly, accidentally, violently, [*or*] as the result of [*any*] suspicious circumstances, or without medical attendance during the 48 hours [*prior to*] IMMEDIATELY PRECEDING the hour of death, unless the attending physician, if any, is able to determine accurately the cause of death, or in any case of death due to what is commonly known as an abortion, whether self-induced or otherwise, shall notify the county medical examiner or his OR HER deputy immediately of the death. A PHYSICIAN OR OTHER INDIVIDUAL DESCRIBED IN THIS SUBSECTION IS NOT REQUIRED TO NOTIFY THE COUNTY MEDICAL EXAMINER OR DEPUTY COUNTY MEDICAL EXAMINER OF THE DEATH OF A PERSON WHO HAS DIED AS A RESULT OF THE PROCEDURES AUTHORIZED UNDER PART 56B OF THE PUBLIC HEALTH CODE, 1978 PA 368, MCL 333.5671 TO 333.5691, UNLESS THE DEATH ALSO OCCURRED AS A RESULT OF VIOLENCE.

"Open meetings act" Sec. 3.

(1) All meetings of a public body shall be open to the public and shall be held in a place available to the general public. All persons shall be permitted to attend any meeting except as otherwise provided in this act. The right of a person to attend a meeting of a public body includes the right to tape record, to videotape, to broadcast life on radio, and to telecast live on television the proceedings of a public body at a8 public meeting. The exercise of this right [*shall*] IS [*not*] be dependent upon the prior approval of the public body. However, a public body may establish reasonable rules and regulations in order to minimize the possibility of disrupting the meeting.
(2) All decisions of a public body shall be made at a meeting open to the public.
(3) All deliberations of a public body constituting a quorum of its members shall take place at a meeting open to the public except as provided in this section and sections 7 and 8.
(4) A person shall not be required as a condition of attendance at a meeting of a public body to register or otherwise provide his or her name or other information or otherwise to fulfill a condition precedent to attendance.
(5) A person shall be permitted to address a meeting of a public body under rules established and recorded by the public body. The legislature or a house of the legislature may provide by rule that the right to address may be limited to prescribed times at hearings and committee meetings only.

(6) A person shall not be excluded from a meeting otherwise open to the public except for a breach of the peace actually committed at the meeting.

(7) This act does not apply to the following public bodies only when deliberating the merits of a case:

(a) The worker's compensation appeal board created under the worker's disability compensation act of 1969, [*Act No 317 of the Public Acts of 1969, as amended, being sections 418.101 to 418.941 of the Michigan Compiled Laws*] 1969 PA 317, MCL 418.101 TO 418.941.

(b) The employment security board of review created under the Michigan employment security act, [*Act No 1 of the Public Acts of the Extra Session of 1936, being sections 421.1 to 421.73 of the Michigan Compiled Laws*]1936 (EX SESS) PA 1, MCL 421.1 TO 421.75.

(c) The state tenure commission created under [*Act No 4 of the Public Acts of the Extra Session of 1937, as amended, being 5 cautions 38.71 to 38.191 of the Michigan Compiled Laws*] 1937 (EX SESS) PA 4, MCL 38.71 TO 38.191, when acting as a board of review from the decision of a controlling board.

(d) An arbitrator or arbitration panel appointed by the employment relations commission under the authority given the 10 commission by [*Act No. 176 of the Public Acts of 1939, as amended, being sections 423.1 to 423.30 of the Michigan Compiled Laws*] 1939 PA 176, MCL 423.1 TO 423.30.

(e) An arbitration panel selected under chapter 50A of the revised judicature act of 1961, [*Act No. 236 of the Public Acts of 1961, being sections 600.5040 to 600.5065 of the Michigan Compiled Laws*] 1961 PA 236, MCL 600.5040 TO 600.5065.

(f) The Michigan public service commission created under [*Act No. 3 of the Public Acts of 1939, being Portions 460 1 to 460.8 of the Michigan Compiled Laws*] 1939 PA 236, MCL 460.1 TO 460.8.

(8) This act does not apply to an association of insurers created under the insurance code of 1956, [*Act No. 218 of the public Acts of 1956, being sections 500.100 to 500.8302 of the Michigan Compiled Laws]* 1956 PA 218, MCL 500.100 TO 500.8302, or other association or facility formed under [*Act No. 218 of the Public Acts of 1956*] THE INSURANCE CODE OF 1956, 1956 PA 218, MCL 500.100 TO 500.8302, as a nonprofit organization of insurer members.

(9) This act does not apply to a committee of a public body which adopts a nonpolicymaking resolution of tribute or memorial which resolution is not adopted at a meeting.

(10) This act does not apply to a meeting which is a social or chance gathering or conference not designed to avoid this act.

(11) This act shall not apply to the Michigan veterans' trust fund board of trustees or a county or district committee created under [*Act No 9 of the Public Acts of the first extra session of 1946, being sections 35 601 to 35.610 of the Michigan Compiled Laws*]1946 (1ST EX SESS) PA 9, MCL 35.601 TO 35.610, when the board of trustees or county or district committee is deliberating the merits of an emergent need. A decision of the board of trustees or county or district committee made under this subsection shall be reconsidered by the board or committee at its next regular or special meeting consistent with the requirements of this act. "Emergent need" means a situation which the board of trustees, by rules promulgated under the administrative procedures act of 1969, Act No 306 of the Public Acts

of 1969, as amended, being sections 24.201 to 24.328 of the Michigan Compiled Laws 1969 PA 306, MCL 24.201 TO 24.328, determines requires immediate action.

Source: Michigan Secretary of State

Appendix H

Washington Death With Dignity Act

JOURNAL OF THE SENATE

The Honorable President of the Senate
Legislative of the State of Washington
Olympia, Washington
Mr. President:

We herewith respectfully transmit for your consideration a copy of Initiative to the Legislature Number 119, originally filed with this office on March 14, 1990. On January 2, 1991, the sponsor of the proposed initiative filed 12,103 signature petition sheets in support of the measure. We have completed our preliminary canvass of these petitions and have determined that they contain 218,317 signatures.

Accordingly, pursuant to the provisions of Article 2, section 1 of the State Constitution, we are provisionally certifying Initiative to the Legislature Number 119 to you at this time. We expect to complete verification of signatures no later than February 15, 1991 and we will provide the Legislature with a final certification as soon as possible thereafter.

IN WITNESS WHEREOF, I have set my hand and affixed the Seal of the state of Washington, this fourteenth day of January, 1991.

(Seal) RALPH NUNRO,
Secretary of State

INITIATIVE TO THE LEGISLATURE NUMBER 119

AN ACT Relating to the natural death act; and amending RCW 70.122.010, 70.122.020, 70.122.030, 70.122.040, 70.122.050, 70.122.060, 70.122.070, 70.122.080, 70.122.090, 70.122.100, and 70.122.900.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

See 1. RCW 70.122.010 and 1979 c112 x2 are each amended to read as follows:

The ((~~legislative~~)) people find((s)) that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have all life-sustaining procedures withheld or withdrawn in instances of a terminal condition, and including the right to death with dignity through voluntary aid-in-dying if suffering from a terminal condition.

The ((~~legislature~~)) people further find((s)) that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The ((~~legislature~~)) people further find((s)) that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition my cause loss of patient dignity, and unnecessary pain and suffering while providing nothing medically or beneficial to the patient.

The ((~~legislature~~)) people further find((s)) that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

The people further find that existing law does not allow willing physicians to render aid-in-dying to qualified patients who request it.

In recognition of the dignity and privacy which patients have a right to expect, the ((~~legislature~~)) people hereby declare((s)) that the laws of the state of Washington shall recognize the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition, and/or to request and receive aid-in-dying under the provisions of this chapter.

Sec. 2, RCW 70.122.020 and 1979 c112s3 are each amended to read as follows:

Unless the content clearly requires otherwise, the definitions contained in this section shall apply throughout this chapter.

(1) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(2) "Directive" means a written document voluntarily executed by the declarer in accordance with the requirements of RCW 70.122.030.

(3) "Health facility" means a hospital as defined in RCW ((~~70.38.0202(7~~) or)) 70.41.020(2) a nursing home as defined in RCW ((~~70.38.020(8~~))) 18.51.010, or a home health agency or hospice agency as defined in RCW 70.126.010.

(4) "Life-sustaining procedure" means any medical or surgical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death ((~~and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized~~)). "Life-sustaining procedure" includes, but is not limited to, cardiac resuscitation, respiratory support, and artificially administered nutrition and hydration, but shall not include the administration of medication to relieve pain of the performance of any medical procedure deemed necessary to alleviate pain.

(5) "Physician" means a person licensed under chapter((s)) 18.71 or 18.57 RCW.

(6) "Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians one of whom shall be the attending physician, who have personally examined the patient.

(7) "Terminal condition" means incurable ((~~condition caused by injury, disease, or illness, which regardless of the application of life sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life sustaining procedures serve only to postpone the moment of death of the patient~~)) or irreversible condition which, in the written opinion of two physicians having examined the patient

and exercising reasonable medical judgment, will result in death within six months, or a condition in which the patient has been determined in writing by two physicians as having no reasonable probability of recovery from an irreversible coma or persistent vegetative state.

(8) "Adult person" means a person attaining the age of majority as defined in RCW 26.28.010 and 26.28.015.

(9) "Aid-in-dying" means aid in the form of medical service provided in person by a physician that will end the life of a conscious and mentally competent qualified patient in a dignified, painless and humane manner, when requested voluntarily by the patient through a written directive in accordance with this chapter at the time the medical service is to be provided.

Sec. 3. RCW 70.122.0303 and 1979c112s4 are each amended to read as follows:

(1) Any adult person may execute at any time a directive directing the withholding or withdrawal of life-sustaining procedures and/or requesting the provision of aid-in-dying when in a terminal condition. The directive shall be signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who would not be entitled to any portion of the estate of the declarer upon declarer's decease under any will of the declarer or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon declarer's decease at the time of the execution of the directive. The directive, or copy thereof, shall be made part of the patient's medical records retained by the attending physician, a copy of which shall be forwarded to the health facility upon the withdrawal of life-sustaining procedures, and/or provision of aid-in-dying. No personal shall be required to execute a directive in accordance with this chapter. Any person who has not executed such a directive is ineligible for aid-in-dying under any circumstances. The directive shall be essentially in the following form, but in addition may include other specific directions:

DIRECTIVE TO PHYSICIANS

Directive made this … day of …..(month, year).

I….., being of sound mind, willfully, and voluntarily make know my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do thereby declare that:

(a) If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death ((~~and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized,~~)):

Declarant must initial one or both of the following:

…….I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

…….I direct that upon my request my physician provide aid-in-dying so that I might die in a dignified, painless and humane manner.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, such as while in an irreversible coma or persistent vegetative state, It is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences ((~~from~~)) of such refusal.

(c) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

(d) I understand the full impact of this directive and I am emotionally and mentally competent to make this directive.

(e) I understand that I may add to or delete from or otherwise change the wording of this directive before I sign it, and that I may revoke this directive at any time.

Signed…………………………
City, County, and State of Residence
The declarer has been personally known to me and I believe him or her to be of sound mind.

Witness……………………………….
Witness……………………………….

(2) Prior to effectuating a directive the diagnosis of a terminal condition by two physicians shall be verified in writing, attached to the directive, and made a permanent part of the patient's medical records.

(3) Similar directives to physicians lawfully executed in other states shall be recognized within Washington state as having the same authority as in the state where executed.

Sec. 4RCW70.122.040 and 1979 c112s5 are each amended to read as follows:

(1) A directive may be revoked at any time by the declarer, without regard to declarer's mental state or competency, by any of the following methods:

(a) By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the declarer or by some person in declarer's presence and by declarer's direction.

(b) By a written revocation of the declarer expressing declarer's intent to revoke, signed, and dated by the declarer. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time and date when said physician received notification of the written revocation.

(c) By a verbal expression by the declarer of declarer's intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when said physician received notification of the revocation.

(2) There shall be no criminal ((or))$_2$ civil, or administrative liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual or constructive knowledge of the revocation.

(3) If the declarer becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarer's condition renders declarer able to communicate with the attending physician.

Sec.5. RCW70.122.050 and 1979 c112s6 are each amended to read as follows:

No physician or health facility which, acting in good faith in accordance with the requirements of this chapter, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom. No licensed health personnel, acting under the direction of a physician, who participates in good faith in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be subject to any civil liability. No physician, or licensed health personnel acting under the direction of a physician, or health facility ethics committee member who participates in good faith in the withholding or withdrawal of life-sustaining procedures and no physician who provides aid-in-dying to a qualified patient in accordance with the provisions of this chapter shall be subject to prosecution for or be guilty of any criminal act or of unprofessional conduct.

Sec.6. RCW70.122.060 and 1979c112s7 are each amended to read as follows:

(1) Prior to effectuating a withholding or withdrawal of life-sustaining procedures from or provision of aid-in-dying to a qualified patient pursuant to the directive, the attending physician shall make a reasonable effort to determine that the directive complies with RCW70.122.030 and, if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are currently in accord with the desires of the qualified patient.

(2) The directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures and/or the provision of aid-in-dying. No physician, and no licensed health personnel acting in good faith under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subsection, and no health facility may be required to permit the provision of aid-in-dying within its facility. If the physician or health care facility refuses to effectuate the directive, such physician or facility shall make a good faith effort to transfer the qualified patient to another physician who will effectuate the directive of the qualified patient or to another facility.

Sec.7. RCW 70.122.070 and 1979 c 112s 8 are each amended to read as follows:

(1) The withholding or withdrawal of life-sustaining procedures from or the provision of aid-in-dying to a qualified patient pursuant to the patient's directive in accordance with the provisions of this chapter shall not, for any purpose, constitute a suicide.

(2) The making of a directive pursuant to RCW70.122.030 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, no shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from or the provision of aid-in-dying to an insured qualified patient, notwithstanding any term of the policy to the contrary.

(3) No physician, health facility, or other health provider, and no health ((~~care~~)) service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan, shall require any person to execute a directive as a condition for being insured for, or receiving, health care services.

Sec.8. RCW 70.122.080 and 1979 c112 s 10 are each amended to read as follows:

The act of withholding or withdrawing life-sustaining procedures or providing aid-in-dying, when done pursuant to a directive described in RCW 70.122.030 and which causes the death of the declarer, shall not be construed to be an intervening force or to affect the chain of proximate cause between the conduct of any person that placed the declarer in a terminal condition and the death of the declarer.

Sec.9. RCW 70.122.090 and 1979 c 112 s 9 are each amended to read as follows:

Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarer's consent shall be guilty of a gross misdemeanor. Any person who falsifies or forges the directive of another((s)) or willfully conceals or withholds personal knowledge of a revocation as provided in RCW 70.122.040 with the intent to cause a withholding or withdrawal of life-sustaining procedures or the provision of aid-in-dying contrary to the wishes of the declarer((s)) and thereby, because of any such act, directly causes life-sustaining procedures to be withheld or withdrawn or aid-in-dying to be provided and death to thereby be hastened, shall be subject to prosecution for murder in the first degree as defined in RCW 9A.32.030.

Sec.10. RCW 70.122.100 and 1979 c 112 s 11 are each amended to read as follows:

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying and to permit death with dignity through the provision of aid-in-dying only be a physician when voluntarily requested in writing as provided in this chapter by a conscious and mentally competent qualified patient at the time aid-in-dying is to be provided.

Sec.11 RCW 70.122.900 and 1979 c 112 s 1 are each amended to read as follows:

This act shall be know and my be cited as the "((~~Natural~~)) Death With Dignity Act ((-))."

NEW SECTION Sec.12. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

Source: Washington Secretary of State

Appendix I

Maine Death With Dignity Act

STATE OF MAINE

To the Legislature of the State of Maine:

In accordance with Section 18 of Article IV, Part Third of the Constitution of the State of Maine, the undersigned electors of the State of Maine, qualified to vote for Governor, residing in said State, whose names have been certified, hereby respectfully propose to the Legislature for its consideration the following entitled legislation:

"The Maine Death with Dignity Act." The full text of this Act is printed on this petition.

SHOULD A TERMINALLY ILL ADULT WHO IS OF SOUND MIND BE ALLOWED TO ASK FOR AND RECEIVE A DOCTOR'S HELP TO DIE?

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 18-A MRSA art. V, Part 9 is enacted read:

PART 9
MAINE DEATH WITH DIGNITY ACT

§5-901. Short title

This Part may be known and cited as the "Maine Death with Dignity Act."

§5-902. Definitions

As used in this Act, unless the context otherwise indicates, the following terms have the following meanings.

(a) "Adult" means a person who is 18 years of age or older.

(b) "Attending physician" means a physician who has primary responsibility for the care of a patient and treatment of that patient's terminal disease.

(c) "Capable" means not incapable.

(d) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease. The consulting physician may not be a partner or similar business associate of the attending physician and may not have an office in the same building as the attending physician.

(e) "Counseling" means a consultation between a counselor and a patient to carry out the purposes set forth in section 5-907.

(f) "Counselor" means a psychiatrist licensed under Title 32, chapter 48 or a psychologist licensed under Title 32, chapter 56.

(g) "Health care provider" means a person licensed, certified or otherwise authorized or permitted by the laws of this State, to administer health care in the ordinary course of

business or the practice of a profession and includes a health care facility.
(h) "Incapable" means that, in the opinion of the patient's attending physician or consulting physician, a patient lacks the ability to make and communicate health care decisions to health care providers.
(i) "Informed decision" means a decision that is made by a qualified patient to request and obtain a prescription to end that patient's life in a humane and dignified manner and that is based on the patient's appreciation of the relevant facts after being fully informed by the attending of:
(1) The patient's medical diagnosis;
(2) The patient's prognosis;
(3) The potential risks associated with taking the medication that is prescribed;
(4) The probable results of taking the prescribed medication; and
(5) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control.
(j) "Medically confirmed" means that the medical opinion of the attending physician is confirmed by a consulting physician who has examined the patient and the patient's relevant medical records.
(k) "Next of kin" includes a family member or an adult who has exhibited special concern for the patient and who is familiar with the patient's personal values.
(l) "Palliative Care Specialist" means a person who is recognized to have expertise in palliative care. A palliative care specialist may be, but is not limited to, a hospice worker, nurse, nurse practitioner, or physician.
(m) "Patient" means a person who is under the care of a physician.
(n) "Personally communicated request" means a request that the patient makes directly in a face-to-face meeting with the attending physician. A "personally communicated request" may be made orally, by sign language or by some other method of communication, including a method using an interpreter, that clearly and unambiguously communicates the patient's intentions.
(o) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine by the Board of Licensure in Medicine or the Board of Osteopathic Licensure.
(p) "Qualified patient" means a capable adult who is a resident of this State and who has satisfied the requirements of this Act in order to obtain a prescription for medication to end that person's life in a humane and dignified manner.
(q) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within 6 months.

§5-903, Written request for medication

(a) A patient who is an adult, is capable, is a resident of this State and is determined by the attending physician and the consulting physician to be suffering from a terminal disease and who has voluntarily expressed the wish to die, may make a written request for medication for the purpose of ending that patient's life in a humane and dignified manner in accordance with this Act.
(b) A valid request for medication under this Act must be in the form described in section 5-921, signed and dated by the patient and witnessed by at least 2 individuals who, in the

presence of the patient, attest that to the best of their knowledge and belief the patient is capable, is acting voluntarily and is not coerced to sign the request.
(1) A witness may not be a person who is:
(i) A relative of the patient by blood, marriage or adoption;
(ii) At the time the request is signed, entitled to any portion of the estate of the qualified patient upon that patient's death, under a will or by operation of law; or
(iii) An owner, operator or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.
(2) The patient's attending physician at the time the request is signed may not be a witness.
(3) If the patient is a resident in a long-term care facility at the time the written request is made, one of the witnesses must be an individual designated by the facility and must have the qualifications specified by the Department of Human Services by a routine technical rule, as defined in Title 5, chapter 375, subchapter II-A.
(4) If the patient is physically unable to make a written request, the attending physician shall enter that fact in the patient's medical record. The patient may then comply with the requirement of a written request by making a separate personally communicated request:
(i) To the attending physician;
(ii) Before 2 witnesses qualified to witness a written request; and
(iii) That is recorded verbatim and transcribed into written form and entered in the patient's medical record.

§5-904, Attending physician's responsibilities
The attending physician shall: (a) Make the initial determination of whether a patient has a terminal disease, is capable and has voluntarily requested medication under section 5-903;
(b) Inform the patient of:
(1) The patient's medical diagnosis;
(2) The patient's prognosis;
(3) The potential risks associated with taking the medication prescribed;
(4) The probable result of taking the medication prescribed; and
(5) The feasible alternatives, including, but not limited to, comfort care, hospice care and pain control;
(c) Refer the patient to a consulting physician for medical confirmation of the diagnosis and for a determination that the patient is capable and acting voluntarily;
(d) Refer the patient to a palliative care specialist pursuant to section 5-906;
(e) Refer the patient for counseling pursuant to section 5-907;
(f) Request that the patient notify the next of kin. If requested by the patient, the physician shall provide assistance in arranging notification of or contact with the patient's next of kin;
(g) Inform the patient of the opportunity to revoke the request for a prescription for medication under this Act at any time and in any manner and offer the patient an opportunity to revoke the request at the end of the 15-day waiting period pursuant to section 5-912;
(h) Verify, immediately before writing the prescription for medication under this Act, that

the patient is making an informed decision;
(i) Fulfill the medical record documentation requirements of section 5-913; and
(j) Ensure that all appropriate steps are carried out in accordance with this Act before writing a prescription for medication to enable a qualified patient to end that patient's life in a humane and dignified manner.

§5-905, Consulting physician confirmation

A patient is qualified under this Act if a consulting physician examines the patient and the patient's relevant medical records and confirms, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease and verifies that the patient is capable, is acting voluntarily and has made an informed decision. The consulting physician shall inquire whether the patient wishes to notify the next of kin if the patient has not already done so. If requested by the patient, the consulting physician shall provide assistance in arranging notification of or contact with the patient's next of kin.

§5-906, Palliative Care Specialist's responsibilities

The palliative care specialist shall determine whether high-quality palliative care has been made available to the patient. The palliative care specialist shall further make all appropriate recommendations and referrals necessary to overcome any deficiencies in the current level of palliative care provided to the patient. Nothing in this section may be construed to limit or restrict in any way a capable patient's right to refuse palliative care or any other type of medical care.

§5-907, Counseling referral

The attending physician and the consulting physician shall refer the patient for counseling. The counselor shall determine whether the patient is suffering from a psychiatric or psychological disorder or depression that causes impaired judgment. Counseling must also include discussion about choosing to die.

Medication to end a patient's life in a humane and dignified manner may not be prescribed until the counselor determines that the patient is not suffering from a psychiatric or psychological disorder or depression that causes impaired judgment.

The counselor shall inquire whether the patient wishes to notify the next of kin if the patient has not already done so. If requested by the patient, the counselor shall provide assistance in arranging notification of or contact with the patient's next of kin.

§5-908, Informed decision

A person may not receive a prescription for medication to end that person's life in a humane and dignified manner unless that person has made an informed decision as defined in section 5-902, subsection (i). Before prescribing medication under this Act, the attending physician shall verify that the patient is making an informed decision.

§5-909, Family notification

The attending physician, consulting physician, and counselor shall ask the patient to notify the next of kin of the patient's request for medication pursuant to this Act. If requested by the patient, the attending physician, consulting physician or counselor shall provide assistance in arranging notification of or contact with the patient's next of kin. A patient who declines or is unable to notify the next of kin may not be denied the request for medication for that reason.

§5-910, Requests

To receive a prescription for medication to end the patient's life in a humane and dignified manner, a qualified patient must personally communicate a request and repeat the personally communicated request to the attending physician no sooner that 15 days after the initial request. Before the 2nd personally communicated request is made, the patient must make the request in writing as described in section 5-903. When the qualified patient makes the 2nd personally communicated request, the attending physician shall offer the patient an opportunity to revoke the request.

§5-911, Right to revoke request

A patient may revoke a request for medication under this Act at any time and in any manner without regard to the patient's mental state. A prescription for medication under this Act may not be written without the attending physician offering the qualified patient an opportunity to revoke the request.

§5-912, Waiting period

No fewer than 15 days may elapse between the patient's initial personally communicated request and the writing of a prescription under this Act. No fewer than 48 hours may elapse between the patient's written request and the writing of a prescription under this Act.

§5-913, Medical record filing requirements

The following information must be filed or noted on a chart in the patient's medical record:

(a) All personally communicated requests by a patient for medication to end the patient's life in a humane and dignified manner;

(b) All written requests by a patient for medication to end the patient's life in a humane and dignified manner;

(c) The attending physician's diagnosis and prognosis and that physician's determination that the patient is capable, is acting voluntarily and is making an informed decision;

(d) The consulting physician's diagnosis and prognosis and that physician's determination that the patient is capable, is acting voluntarily and is making an informed decision;

(e) A report of the determination made during counseling;

(f) The attending physician's offer to the patient to revoke the request at the time of the patient's 2nd personally communicated request pursuant to section 5-910; and

(g) A note by the attending physician stating that requirements under this Act have been met and indicating the steps taken to carry out the request and the medication prescribed.

§5-914, Residency requirement

Only persons who have been residents of this State for at least 6 months immediately preceding the request may make and be granted requests under this Act.

§5-915, Reporting requirements

(a) The Department of Human Services, Bureau of Health shall annually review records maintained pursuant to this Act.
(b) The Department of Human Services, Bureau of Health shall adopt rules to facilitate the collection of information in compliance with this Act. The information is not a public record and is not available to the public.
(c) The Department of Human Services, Bureau of Health shall make available to the public an annual statistical report of information collected under subsection (b).

§5-916, Effect on construction of wills, contracts and laws

(a) A provision in a contract, will or other agreement, whether written or oral, to the extent the provision affects the decision of a person to make or revoke a request for medication to end the person's life in a humane and dignified manner, is not valid.
(b) An obligation owing under any existing contract is not conditional to or affected by the making or revoking of a request for medication under this Act to end the person's life in a humane and dignified manner.

§5-917, Insurance or annuity policies

Benefits payable under a life, health or accident insurance or annuity policy are not affected by making or revoking a request under this Act for medication to end the patient's life in a humane and dignified manner. A qualified patient's act of ingesting medication to end that patient's life in a humane and dignified manner may not have an effect upon benefits payable under a life, health or accident insurance or annuity policy.

§5-918 Construction

(a) This Act may not be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia. Actions taken in accordance with this Act do not, for any purpose, constitute suicide, assisted suicide, mercy killing or homicide.
(b) This Act may not be construed to authorize any person to assist in the administration of medication prescribed under the provisions of this Act.

§5-919, Immunities

Except as provided in Sec. 5-920, the following immunities apply:
(a)The Act may not be construed to repeal the State prohibition against assisted suicide except that a person or entity may not be subjected to civil or criminal liability or professional disciplinary action for participating in good-faith compliance with this Act. The requirement of good faith is an additional requirement and not a substitute for the reasonable standard of care otherwise imposed upon health care providers in the exercise of their professions.
(b) A professional organization or association or health care provider may not subject a

person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership or any other penalty for participating or refusing to participate in good faith in any act under this Act.

(c) A request by a patient for medication or provision of medication by an attending physician in accordance with the provisions of this Act does not provide the sole basis for the appointment of a guardian or conservator. The provision of medication to a qualified patient does not constitute neglect on the part of an attending physician.

(d) A health care provider is not under a duty, whether by contract, by law or by any other legal requirement, to provide medication to end the patient's life in a humane and dignified manner. If a health care provider is unable or unwilling to carry out a patient's request under this Act and the patient transfers that patient's care to a new health care provider, the prior health care provider shall transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

(e) A pharmacist is not under a duty, whether by contract, by law or by any other legal requirement, to fill a prescription written in accordance with this Act that the pharmacist knows or has reason to know is intended to be ingested by a qualified patient to end that patient's life in a humane and dignified manner. If a pharmacist is unable or unwilling to fill a prescription under this Act, the pharmacist shall make that inability or refusal known to the patient, who may then seek another pharmacist to fill the prescription.

§5-920, Liabilities

(a) A person who, without authorization of the patient, willfully alters or forges a request for medication or conceals or destroys a revocation of that request with the intent or effect of causing the patient's death commits a Class A crime.

(b) A person who coerces or exerts undue influence on a patient to request medication for the purpose of ending the patient's life or to destroy a revocation of such a request commits a Class A crime.

(c) This Act does not limit liability for civil damages resulting from negligent conduct or intentional misconduct by any person or entity.

(d) The penalties in this Act do not preclude criminal penalties applicable under other law for conduct that is inconsistent with the provisions of this Act.

§5-921, Form of request

A request for medication as authorized by this Act must be substantially in the following form.

REQUEST FOR MEDICATION TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER

I _________________ am an adult of sound mind.

I am suffering from _________________ which my attending physician has determined is a terminal disease and which has been medically confirmed by a consulting physician. I have been fully informed of my diagnosis and prognosis, the nature of the medication to be prescribed and its potential associated risks, the expected result of taking the medication and the feasible alternatives to ending my life in a humane and dignified

manner, including comfort care, hospice care and pain control.
I request that my attending physician prescribe medication that will end my life in a humane and dignified manner.

INITIAL ONE:

____I have informed my family or next of kin of my decision and I have taken their opinions into consideration.
____I have decided not to inform my family or next of kin of my decision.
____I have no family or next of kin to inform of my decision.

I understand that I have the right to revoke this request at any time. I understand the full importance of this request, and I expect to die when I take the medication to be prescribed.

I make this request voluntarily and without reservation.

Signed:___________________________ Dated:________________________

DECLARATION OF WITNESSES

We declare that the person signing this request:

(A) Is personally known to us or has provided proof of identity;

(B) Signed this request in our presence;
(C) Appears to be of sound mind and not to be under duress or fraudulent or undue influence; and
(D) Is not a patient for whom either of us is the attending physician.

________________________Witness 1 __________________Date
________________________Witness 2 __________________Date

Note: Neither witness may be a relative by blood, marriage or adoption of the person signing this request, may be entitled to any portion of the person's estate upon death or may own, operate or be employed at a health care facility where the person is a patient or a resident. If the patient is an inpatient at a health care facility, one of the witnesses must be an individual designated by the facility.

SUMMARY

This initiated bill creates the Maine Death with Dignity Act. It allows a mentally competent adult who is suffering from a terminal illness to request and obtain medication from a physician to end that patient's own life in a humane and dignified manner, with safeguards to ensure that the patient's request is voluntary and based on an informed decision.

Source: Maine Secretary of State