

PHYSICIAN-ASSISTED DYING

THE CASE FOR PALLIATIVE CARE & PATIENT CHOICE

EDITED BY TIMOTHY E. QUILL, M.D. AND
MARGARET P. BATTIN, PH.D.

THE JOHNS HOPKINS UNIVERSITY PRESS
2715 NORTH CHARLES STREET
BALTIMORE, MARYLAND 21218-4363
2004

CHAPTER 17, PAGES 245-263
WRITTEN BY ELI D. STUTSMAN, J.D.

Political Strategy and Legal Change

Eli D. Stutsman, J.D.

Oregon has experienced unprecedented legal and political reform since the 1994 passage of the Oregon Death with Dignity Act.¹ The significance of the *legal* reform in Oregon is demonstrated by the very existence of the act, the only law of its kind in the United States. No other state provides its citizens with a comprehensive list of statutory criteria that, once satisfied, permit a physician to openly assist a competent terminally ill adult patient seeking to hasten his or her impending death.²

The significance of the *political* reform in Oregon is demonstrated by a remarkable measure of voter and institutional support for the act. The Oregon Death with Dignity Act is supported by nearly seven out of ten Oregon voters and by key statewide officials, including Governor Ted Kulongoski, former governor John Kitzhaber (a physician whose tenure from 1994 to 2002 overlapped the critical period for reform in Oregon), Oregon secretary of state Bill Bradbury, and Oregon treasurer Randall Edwards.³ When faced with threats from Congress, the Oregon law has been rigorously defended by six out of seven members of the Oregon congressional delegation.⁴ Although Oregon attorney general Hardy Myers does not personally support the state's novel law, he too has mounted a strong defense against federal challengers.⁵ Finally, in a 2002 survey that asked candidates their position on the Death with Dignity Act, twelve of the thirty state senators and twenty-five of the sixty state representatives serving in the 2003 Oregon legislature supported the law in writing.⁶

Support for Oregon's new law cuts across party, faith, and gender lines. Polling conducted after the 1997 campaign revealed that a majority of both Democrats (72 percent) and Republicans (51 percent) supported Oregon's new law, with

the strongest support coming from nonaffiliated independents (83 percent). The same survey also showed strong support across gender lines (60 percent of women and 70 percent of men) and faith affiliations (56 percent of Catholics, 60 percent of Protestants, and 89 percent of those professing no religion).⁷ Such strong support from lay Catholics may come as a surprise given that most of the money spent in opposition to death-with-dignity legislation comes from the political arm of the Catholic Church.

If you want to hold public office in Oregon, you will be expected to announce your position on death with dignity, and your position will matter. Indeed, in Oregon today, an elected official's position on death with dignity is arguably the single most important political litmus test. During the 2002 gubernatorial primary, all three Democratic candidates and all three Republican candidates pledged their support for the Oregon Death with Dignity Act.⁸ That all six candidates felt compelled to announce their position in favor of death with dignity during a primary race for the votes of their own party is both extraordinary and yet expected. During the same 2002 election cycle, in a statewide survey for the U.S. Senate race, 45 percent of Oregon voters sampled responded that Republican senator Gordon Smith's effort to overturn the Oregon Death with Dignity Act was a "very convincing" reason to vote him out of office;⁹ when measuring voter sentiment on a social issue, 45 percent is a huge number. In comparison, 41 percent of respondents believed that Senator Smith's effort to overturn *Roe v. Wade*, the landmark decision that permits legal abortion, was a "very convincing" reason to vote against him. All other issues tested in that same survey, including gun control, social security, minimum wage, tax cuts, environmental pollution, and toxic waste cleanup, were of less importance to Oregon voters. Any issue that is so demonstrably important to voters will draw the attention of every serious political candidate, pollster, and strategist, friend or foe.

In the ten short years from 1993 to 2002, an extraordinary legal and political transformation has occurred in Oregon but not elsewhere. Indeed, outside of Oregon, although popular support remains high, there is no vestment of public authority and little political legitimacy for death with dignity. What makes Oregon so different? How did a social issue like death with dignity become a political litmus test?

Popular Support at the National Level

Oregon voters are not unique in their support for death with dignity. Strong popular support has been demonstrated in public opinion polls since the early 1970s. Whether the question is posed in a national or state survey or is framed

as a matter of an individual's right or the federal government's attempts at intervention, public opinion consistently supports death-with-dignity reform.

It was not always so. In 1947, 54 percent of respondents to a Gallup survey answered no when asked, "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end a patient's life by some painless means if the patient and his family request it?"¹⁰ At that time, only 37 percent of respondents were in favor, and 9 percent responded either "don't know" or "no answer." Twenty-six years later, however, when the exact same question was posed again, these numbers were nearly reversed: 53 percent in favor of allowing a hastened death, 34 percent opposed, and 7 percent "don't know" or "no answer."¹¹

From that point forward, national surveys established a record of steadily increasing support for death with dignity, climbing rapidly in the mid-1980s, roughly coinciding with advances in medical science that extended end-of-life dilemmas beyond anything possible just a few generations ago. Surveys conducted between 1988 and 1993 show a 15 percent surge in support for death-with-dignity reform during this short period of time. In 1998 fully 58 percent of those asked, "When a person has a painful and distressing terminal disease, do you think doctors should or should not be allowed by law to end the patient's life if there is no hope of recovery and the patient requests it?" said it should be legal; 27 percent said it should not, and 14 percent said either "don't know" or "no answer."¹²

In 1990 Gallup repeated the question asked in 1947 and 1973; this time, 65 percent supported legalizing physician-assisted dying, 31 percent opposed, and only 4 percent said "don't know" or "no answer."¹³ A 1993 Harris poll asked the question slightly differently: "Do you think that the law should allow doctors to comply with the wishes of a dying patient in severe distress who asks to have his or her life ended, or not?" Seventy-three percent of respondents to this survey were in favor of assisted dying, 24 percent were opposed, and 3 percent answered "don't know" or "no answer."¹⁴ The upward trend didn't stop in 1993. In 1996, two years after voters in Oregon approved the first-in-the-nation law permitting a physician-assisted death, Gallup recorded its highest numbers ever to the same question it asked in 1947, 1973, and 1990 when respondents said they favored such laws by a margin of 75 percent to 22 percent, with 3 percent saying "don't know" or "no opinion."¹⁵

Popular Support at the State Level

Public opinion surveys confined to statewide voter samples have produced results similar to those obtained from the national surveys canvassed above. As

has been noted, popular and institutional support for death with dignity within Oregon is at an all-time high. Surveys fielded in other states, including Maine in 1998, Hawaii in 2002 and 2003, Vermont in 2003, and Arizona in 2003, all indicate, as in Oregon and the nation as a whole, a high level of popular support for death-with-dignity reform. In a 1998 survey of Maine voters, for example, 63 percent of the respondents answered yes when asked, "Do you want Maine to allow terminally ill adult patients the voluntary informed choice to obtain a physician's prescription for drugs to end life?" Thirty-one percent opposed the statement, and 5 percent were not sure.¹⁶

In a 2002 survey of Hawaii voters, 72 percent of respondents answered in favor of legalizing physician-assisted death when asked, "Would you favor or oppose legislation giving terminally ill persons of sound mind the right to have physician assistance in dying, if the bill included appropriate safeguards to protect against potential abuse?" Only 20 percent opposed, and 7 percent were not sure.¹⁷ This same question received 71 percent support in Hawaii in 2003 and 68 percent support in Vermont.¹⁸

Also in 2003, Arizona voters were asked, "When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should be allowed by law to assist the patient to commit suicide if the patient requests it? Or not?" Respondents supported the concept of assisted dying by 57 percent; 32 percent opposed, and 6 percent said it "depends on circumstances." Five percent said "don't know" or refused to answer.¹⁹

Popular Opposition to Government Intrusion

Although it is more common to pose questions that solicit a respondent's level of support for an idea or cause, sometimes it is more useful to rephrase the question to reflect the work at hand. In a 1998 national survey, fielded during the first of two congressional attempts to nullify Oregon's law, respondents were asked, "Do you favor or oppose Congressional legislation that would prohibit physicians from prescribing medications that terminally ill patients could take to end life?" Respondents nationwide opposed such legislation almost three to one, with 72 percent opposed, only 26 percent in favor, and 2 percent not sure.²⁰ That same survey asked a generic question about support for death-with-dignity legislation by asking respondents to agree or disagree with the following statement: "People in the final stages of a terminal disease that are suffering and in pain should have the right to get help from their doctor to end life, if they so choose." Seventy-four percent of respondents agreed with the

statement, 25 percent disagreed, and 1 percent were not sure.²¹ This study was conducted in response to the 1998 Lethal Drug Abuse Prevention Act, which, had it passed Congress, would have nullified the Oregon Death with Dignity Act. The failed Lethal Drug Abuse Prevention Act was followed by the Pain Relief Promotion Act of 1999, a similar law targeted at Oregon that also failed to pass Congress.

Opponents of Oregon's Death with Dignity Act seized new opportunities in 2001 with the advent of the second Bush administration and the arrival of Attorney General John Ashcroft. In his former role as a U.S. senator from Missouri, Ashcroft had cosponsored the federal legislation against Oregon's death-with-dignity law. In his first year as attorney general, and just weeks after the September 11, 2001, terrorist attacks, Ashcroft issued an enforcement directive to the Drug Enforcement Administration, over which he now presides, directing DEA agents to prosecute Oregon physicians practicing in accord with the Oregon Death with Dignity Act. Soon thereafter, a national survey revealed that Americans continued to support physician-assisted dying and were also overwhelmingly opposed to Attorney General Ashcroft's efforts in Oregon. After hearing a description of Oregon's law in a previous question, respondents were asked, "This proposition, allowing physician-assisted suicide, was approved by a majority in Oregon. Attorney General Ashcroft recently moved to overrule [Oregon's law], which he says is now illegal. Do you think Attorney General Ashcroft was right or wrong to do this?" A strong majority, 58 percent, opposed the attorney general's intervention, 35 percent supported it, and 7 percent were not sure.²²

In sum, support for death with dignity is consistently strong within and outside of Oregon and still trending upward. Although Oregon has advanced death-with-dignity reform like no other state, it would be wrong to attribute that development primarily to characteristics of the Oregon voter.

Converting Public Support into Public Policy

The challenge of any political effort is to leverage popular support, using it as a driving force to shape new public policy. Although the polling technique offers a valid measure of public support, its limitations are often misunderstood. Public opinion surveys offer only a snapshot, fixed in time, of public sentiment under carefully limited circumstances. Political campaigns attempt to replicate the polling experience but in a vastly different setting. Statewide public opinion surveys pose carefully controlled questions to a small sample of voters, usually

four hundred to six hundred respondents, during a fifteen- to twenty-minute interview. In sharp contrast, political campaigns often last a year or longer, consume vast amounts of human and financial resources, and are spread across an entire state in what may best be described as a protracted battle for a majority of dollars and then votes. In this real-world setting, defenders of the status quo fight mightily to control the debate while enjoying the benefits of tradition, money, organization, inertia, fear, and influence within the stakeholder community. Popular support alone is no match for the well-organized, well-funded defender of the status quo. An early lead in the polls that is unprotected by smart, well-funded political strategies will quickly be lost. This is particularly true when dealing with sensitive issues that affect law, medicine, and religion at once. Armed with this understanding, it is possible to briefly assess the various wins and losses involving death-with-dignity reform in and outside of Oregon.

Campaigning for Death with Dignity

Legal reformers have utilized both the citizen-sponsored initiative process available in twenty-four states and the traditional legislative process available in all fifty states.²³ For purposes of this chapter, however, useful data are gleaned from the six initiative campaigns fought in Washington (1991), California (1992), Oregon (1994 and 1997), Michigan (1998), and Maine (2000) and one legislative effort waged in Hawaii (2002). The two victories in Oregon and the recent near victories in Maine and Hawaii have much in common; the larger losses in Washington and California, and particularly Michigan, represent a different type of animal.

Washington's Initiative 119

The first significant initiative campaign occurred in 1991 in the state of Washington, where proponents of Initiative 119 sought to revise state law to allow euthanasia by lethal injection. Although Initiative 119 failed 46 to 54 percent because proponents' paid advertising campaign, or "media buy," was too short, too sparse, and too soft, this campaign was significant because it nonetheless provided skilled observers with the first professional statewide political contest involving death with dignity. Much has been and still can be learned from this first mature political effort.

California's Proposition 161

The second significant initiative campaign occurred in 1992 in California, where proponents sought to pass Proposition 161, a lengthy proposal also designed to allow euthanasia by lethal injection. Unlike the Washington campaign, the California campaign was a true grassroots effort that depended almost exclusively on volunteers, political handbilling (passing out literature), and free media. Opponents were anything but grassroots, however, invoking the toughest political strategies and outspending proponents significantly.

Although the California campaign was a very different campaign waged in a very different state, it failed by the same margin as the Washington initiative the year before, 46 to 54 percent, leading many to conclude that the expensive polling and paid media used during the Washington campaign added nothing to the eventual outcome. The more accurate view, however, is that opponents in California had to shift more voters (using 1990 figures, California's population was six times that of Washington) out of the "yes" column and into the "no" column—hard work that is accomplished with paid media, a costly endeavor in California's far more expensive, diverse, and numerous media markets.²⁴ But with sufficient funds, it is relatively easy to prevail over a defenseless grassroots campaign. In the end, owing to the sheer size of the voting population, far more "yes" voters were converted into "no" voters in California than in Washington; yet the election-day margin, expressed as a percentage, turned out the same, masking the true nature of the California defeat.

Oregon's Measure 16

The third and certainly most significant campaign occurred in 1994 in Oregon, where proponents succeeded in passing Measure 16, the Oregon Death with Dignity Act, by a margin of 51 to 49 percent. Unlike Washington's Initiative 119 or California's Proposition 161, Oregon's Measure 16 expressly prohibited "lethal injection, mercy killing [and] active euthanasia," causing many to erroneously conclude that Oregon's success was derived from little more than a political compromise or, as characterized by some right-to-die activists, a political sellout.²⁵

The Oregon campaign was also notable because its political strategies were informed by the earlier defeats in Washington and California. While it is true that strategists in Oregon offered a fresh policy proposal—a "prescribing only" bill that prohibited lethal injection—they also inoculated Measure 16 by building

in numerous safeguards that were crafted in direct response to the political rhetoric espoused by opponents during the 1991 and 1992 Washington and California campaigns.

Oregon's Measure 51

The fourth and equally significant campaign also occurred in Oregon when, during the 1997 legislative session, the Oregon Catholic Conference successfully lobbied the state legislature to place a repeal measure, House Bill 2954, later named Measure 51, on the November ballot. Measure 51 was designed to repeal Oregon's Death with Dignity Act, which was still tied up in litigation in federal court and had not yet been implemented. The measure was referred to the ballot because Governor Kitzhaber signaled the legislature that he would veto a direct repeal. By placing Measure 51 on the 1997 ballot for voter approval or rejection, the legislature avoided the governor's veto pen. Measure 51 went down to a stunning defeat when voters turned out 60 to 40 percent against repeal of Oregon's new law. By election day 1997, Measure 51, which began as a Catholic Conference lobbying effort in the opening days of the 1997 legislative session, had become a major political blunder. After two statewide elections, the will of the voters could not have been clearer, and the tired argument that Measure 16 was passed by too slim a margin in 1994 became irrelevant.

Michigan's Proposal B

The fifth significant initiative campaign occurred in 1998 in Michigan, where grassroots proponents, attempting to take a page from the Oregon playbook, introduced Proposal B, a prescribing-only bill modeled after Oregon's new law. Although support started out quite high, Proposal B met a stunning defeat when voters turned out 71 percent against it. The essential lesson for the political novice was that the Oregon victories could not be explained simply as the fruit of a narrow, prescribing-only bill that prohibited lethal injection and euthanasia. Although some have surmised that the antics of Dr. Jack Kevorkian doomed Proposal B from the start, an Oregon-style death-with-dignity law would have eliminated the legal loopholes exploited for years by Dr. Kevorkian, and a skilled political strategist would have painted Dr. Kevorkian as the target of reform. For skilled political observers, the loss in Michigan came as no surprise at all—a grassroots campaign is defenseless against the politically ex-

perienced, well-organized, and well-funded opponents of death-with-dignity reform.

Maine's Question 1

The sixth significant initiative campaign occurred in 2000 in Maine, where a small coalition sponsored Question 1, a proposal modeled closely after the Oregon law. This campaign was significant because it was the first attempt to replicate not only the Oregon law but also the now-proven political strategy developed in Oregon. Question 1 nearly passed, failing by a narrow margin of 51 to 49 percent. Although the effort to replicate Oregon's political strategy was incomplete, particularly the free-media and litigation strategies, and the paid political advertising was uninspiring and ultimately ineffective, it was a close race, and this was the first time proponents experienced near success outside of Oregon.

Hawaii's House Bill 2487

The final campaign occurred in 2002 in the Hawaii legislative assembly. Hawaii House Bill 2487 was also modeled closely after the Oregon law. Sponsored by Governor Ben Cayetano, the Hawaii Death with Dignity Act passed the House Judiciary Committee ten to one (with three excused), a near consensus, and the House floor thirty to twenty, revealing a remarkably high level of support from a state legislature.²⁶ From there, the Hawaii proposal moved to the Senate Judiciary Committee, where the committee chair held the bill hostage, refusing to bring it to a vote. Soon, however, a majority of senators sidestepped the committee chair when the Senate voted fifteen to ten to pull the bill from committee. That same day, the Senate voted thirteen to twelve to approve the bill and send it to a final vote by the full Senate.²⁷ It is worth noting that the same number of votes necessary to pull the bill from committee and then to authorize a full senate vote (that is, a simple majority) was all that was needed to pass the proposal out of the senate and on to the governor, who had requested the bill in the first place and was by now lobbying for its passage and ready to sign it into law. In the end, however, the Catholic Church marshaled its resources, and two senators had changed their position by the time the full Senate voted fourteen to eleven against passage.²⁸ A near success, the Hawaii Death with Dignity Act was only two Senate votes away from becoming the

second death-with-dignity law in the nation, a significant accomplishment. Until this time, no death-with-dignity proposal had come within striking distance of success in a state legislature.

A Portal to the Modern Era

The period between 1990 and 2003 was pivotal for the death-with-dignity movement in three key respects. First, the political balance within the movement shifted to a centrist position, with the 1991 and 1992 Washington and California campaigns marking the end of the “euthanasia era” in this country. There have been no serious (that is, well-funded or well-organized) efforts to pass euthanasia legislation since. Until 1992, movement leadership had always been in favor of euthanasia by lethal injection, and debate had focused on whether a proposed initiative should be long or short on clinical details (compare Washington’s short Initiative 119 to California’s lengthy Proposition 161) or whether euthanasia should be limited to the competent terminally ill adult patient or extended to those who are chronically ill, incompetent, or not yet adults. Today, these ethical debates may provide useful teaching tools in academic settings, but they have become irrelevant in mainstream political discussions and, perhaps, always were.

Second, the disastrous loss in Michigan in 1998 dispelled the notion that grassroots reformers, relying almost entirely on high popular support and an Oregon-style prescribing-only law, have any chance of success against well-funded, well-organized defenders of the status quo. The modern political treatment of the issue that began in Oregon in 1992 and later led the way to victories there in 1994 and 1997, together with the near wins in Maine in 2000 and Hawaii in 2002, contains certain key elements and has much to teach. One lesson is that popular support for death-with-dignity reform is no substitute for political money, skill, and organizing. The political tactics adopted by the reformers must be up to the challenge of defeating the political tactics of the defenders of the status quo.

Third, the shift away from a focus on voluntary euthanasia called for new “ownership,” which is often necessary to rehabilitate a hot-button social issue and make political success possible. It is difficult, if not impossible, for someone who has long advocated voluntary euthanasia to sustain political credibility when he or she suddenly asserts that the political balance is properly struck with a prescribing-only bill. Moreover, advocates of voluntary euthanasia have occasionally put themselves harshly at odds with organized medicine, refusing

to acknowledge that there are a myriad of competing interests that, in the end, must balance. As the discussion at the beginning of this chapter demonstrates, community stakeholders and public officials will rigorously support death-with-dignity reform so long as political strategists make the issue “safe”—by abandoning euthanasia proposals and hapless campaign strategies, to name two examples.

Political Tactics

The Oregon strategy has at its core a steadfast commitment to rebalancing the competing interests at play in death with dignity to assuage the concerns held by the larger stakeholder community and in so doing to reposition the death-with-dignity issue on the political spectrum, complete with new ownership and sophisticated, well-organized, well-funded political strategies. Oregon has relied on this approach during a decade of success. The recent near wins in Maine and Hawaii are the direct result of invoking the Oregon strategy.

Framing the Issue

Among the politically minded, political work begins with framing the issue, something that we all do at one level or another throughout our lives. When young children formulate a carefully worded question and then present that question to one parent rather than the other, they have both framed the issue and selected a target audience, the goal being to sway a yes vote. By obtaining a yes vote from the easy parent, they have won an endorsement with which to lobby the more difficult parent. The child is now coalition building, working to obtain majority support. The same strategy is at the core of political work, although the questions are much more complicated and the voters far more numerous and varied, as are the institutional stakeholders whose endorsements may be needed in order to win and, if not to win, to succeed with the new policy after the initial political victory.

Although political strategies differ markedly between ballot measure campaigns and legislative campaigns, the issues that arise are often remarkably similar. This is because in a ballot measure campaign the people raise their concerns directly, whereas in a legislative campaign, the same or similar concerns emerge from the people through their elected representatives. In either case, however, the political sides frame the arguments and the institutional stakeholders ultimately confer the persuasive and often necessary endorsements

on one side or the other. In other words, because the same stakeholders are involved, similar competing issues arise, the primary difference being who gets to vote and what strategies will succeed in persuading that vote.

When framing the issue, it is also good to remember that a certain percentage of voters or legislators will support reasonable death-with-dignity reforms and a certain percentage will not. These two voting segments provide the base of support for and against. The goal when framing the issue is to maintain current levels of support while simultaneously persuading soft or undecided voters in the middle to swing your way, thus creating a majority. Framing the issue is important not only because a well-framed issue encourages support but also because, as the Oregon experience demonstrates, when it is done well, it balances competing policy interests, resulting in a law that is both operationally feasible and politically defensible for years to come, despite the sensitive nature of the subject matter. The Oregon Death with Dignity Act serves as an example of successful framing with respect to several issues—particularly the prohibition against euthanasia, the restriction of assisted death to cases of terminal illness, and age and competency requirements.

Despite some popular enthusiasm for Dr. Kevorkian, the Netherlands, or euthanasia, such people, places, and activities help to make the case *against* death-with-dignity reform. As a matter of public policy in the United States, physicians should not practice as mavericks without boundaries, public laws should not be loosely defined, and it is not possible to balance the competing public interests to make euthanasia politically feasible. Consequently, successful legislation will necessarily outlaw such activity in no uncertain terms. This is one of the hallmarks of the Oregon Death with Dignity Act. It is a prescribing-only bill, expressly prohibiting “lethal injection, mercy killing or active euthanasia.”²⁹ Moreover, the Oregon law establishes a comprehensive standard of care, leaving no room for the antics of a Dr. Kevorkian.

To qualify under the Oregon law, a patient must be suffering a terminal disease and have less than a six-month life expectancy.³⁰ This restriction has led some to complain that the Oregon law discriminates against patients suffering from debilitating chronic disease. There is, however, little public support for such unrestricted reform, and no campaign will succeed if it must defend permitting a hastened death for those who are chronically ill.

Adulthood and competency are both required under the Oregon law.³¹ This has prompted a few activists to urge that the option of a hastened death be extended to an incompetent adult or a competent juvenile facing a terminal ill-

ness with a life expectancy of less than six months, but again, no campaign will succeed if such activity must be defended.

These brief examples reveal tough, calculated decisions about what is politically feasible. Depending on one's perspective, these political compromises may be attacked as a political sellout or praised as good public policy. For Oregonians, these political compromises provide safe and sensible death-with-dignity reform. They also codify (legalize) what many will acknowledge as the existing covert practice of hastening a difficult death.³²

Other provisions of the Oregon law serve to remove the uncertainty that would otherwise prevail. For example, the attending and consulting physician requirements, the informed decision requirement, and the written request, waiting periods, and witness requirements not only facilitate the standard of care but also ensure good decision making.³³ Similarly, the statutory charting requirements, combined with the public disclosure requirements, ensure public oversight.³⁴ In sum, the law is both good medicine and good politics, making the practice safe while simultaneously inoculating against political attack.

Other examples taken from the Oregon law are more purely political. For example, in an honest debate, a residency requirement for a private-pay patient seeking care from an Oregon physician serves no medical purpose. Nevertheless, observations made during the Washington and California campaigns uncovered the overheated political argument that without such a requirement Oregon would become a "suicide destination state," so the Oregon law contains a residency requirement.³⁵

Defining Ownership of the Issue

Who "owns," or sponsors, an issue is every bit as important as how it is framed. At the end of the political day, the task of every campaign is to deliver a well-framed message through well-chosen messengers. A well-framed issue sponsored by the wrong people is immediately suspect. When an issue is advanced by the wrong owners, institutional stakeholders may stand back and watch, but they are more likely to quickly oppose reform. For this reason, it is not helpful for the death-with-dignity issue to be owned exclusively by the so-called right-to-die groups, particularly those that champion voluntary euthanasia. It was no coincidence that the Oregon Death with Dignity Act was publicly sponsored by a nurse, a physician, and a surviving spouse. Public opinion research consistently demonstrates that, with respect to death-with-dignity reform, voters find

the opinions of nurses to be most persuasive, physicians and family members coming in a close second. That both sides have polled and proved this fact is apparent from mirror-image political strategies that have placed nurses, physicians, and family members at the front line of the political debate. This is also why the political arm of the Catholic Church, although leading and funding the opposition campaigns, prefers to remain behind the scenes.

Defining the Opposition

It is not enough merely to define the issue and the message. It is further necessary to define the opposition, for they are sure to be employing the same strategies. With respect to the death-with-dignity debate, when a few layers of political resistance are peeled back, it becomes clear that the well-organized, well-funded political arm of the Catholic Church is the primary political opponent. Exposing the role of the Catholic Church is problematic for many and, even when it is handled well, may lead to claims of Catholic-bashing by the church, a church that has at times been victimized by social movements but also has a blemished record of its own in this regard. Fear of political reprisal has led some to shrink from the challenge.

To be successful, however, reformers cannot be timid but must earnestly expose the true nature of the political opposition so that the policy debate can be cast in accurate terms. For example, most people are surprised to learn that during the six initiative campaigns and the one legislative campaign that took place from 1991 to 2002, most of the opposition's money and political expertise came from the Catholic Church. Indeed, organized medicine had relatively little to do with the defeats in Maine and Hawaii, whereas the church had almost everything to do with them. The public record bears this out. The Catholic Church provided

- \$745,951 (64.5 percent of the opponents' budget) in Washington state in 1991,³⁶
- \$2,199,986 (60.6 percent) in California in 1992,³⁷
- \$968,806 (59.3 percent) in the first Oregon campaign in 1994,³⁸
- \$1,677,699 (73.6 percent) in Oregon in 1997,³⁹
- \$2,173,330 (38.0 percent) in Michigan in 1998,⁴⁰ and
- \$1,288,894 (fully 73.9 percent) in Maine in 2000.⁴¹

Even during the 2002 Hawaii legislative campaign, where expenditures for political advertising played a far smaller role than in a statewide ballot measure campaign, the Catholic Church nonetheless emerged as the primary opponent.⁴²

What is perhaps most surprising about these expenditures is that they *understate* the total Catholic contribution in that these figures include only what can be gleaned from public contribution and expenditure reports. In other words, these totals represent Catholic contributions that are easily recognizable in the public record from the name of the donor alone—for example, the Archdiocese of Portland—but they do not reflect political contributions from individual Catholic donors, who may be making contributions at the behest of their church or because they are Catholic. That these percentages represent only institutional contributions is all the more telling. Politically speaking, death-with-dignity reform faces one primary political opponent, the political arm of the Catholic Church.

Consider the political impact. The Catholic Church provided nearly three-quarters of the opposition budget during the 2000 campaign in Maine, where proponents held on to a steady lead for more than a year. Both sides ran six-week advertising campaigns, and it was a close race, a cliff-hanger too close to call for much of election night. By the next morning, however, the final vote was reported at 48.5 percent in favor, 51.5 percent opposed. A shift of 9,727 no votes, out of 633,561 total votes cast, would have turned the election. In a close contest like the Maine campaign, had the Catholic Church's contribution been anything less than the astounding 73.9 percent of the opponents' budget, the ballot measure would most likely have passed.

What Makes Oregon Different?

The answers to the questions raised at the beginning of this chapter—Why is Oregon so different? Why did death-with-dignity reform succeed in Oregon but fail in other states?—are manifold. Oregon's experience shows that popular support, in and of itself, does not guarantee success. As the foregoing discussion reveals, the Oregon Death with Dignity Act is first and foremost a political document, one that effectively balances competing public policy concerns in ways that have allowed it to retain high percentages of popular support while simultaneously recruiting mainstream institutional support.

A well-crafted document, however, is not enough. The politics of social reform is a race to define the issue, its proponents, and its opponents. Political success demands a well-framed message delivered by well-chosen messengers against a well-defined opponent. Reform efforts elsewhere cannot simply copy the Oregon law and expect to succeed.

If the goal is to win a political contest, then one must accurately assess the

opponents' strengths, weaknesses, and preferred political tactics. Death-with-dignity reformers have too often adopted the wrong policy or political strategy without due regard to the task at hand, thereby losing the race before it begins. In California, for example, reformers were advised that they had the benefit of strong public support, which was true, and that the primary task therefore was to collect enough signatures to put Proposition 161 on the ballot so that the people could vote on it,⁴³ which was naive. Once the proposal was on the ballot, the opposition campaign spent its money, ran its political advertisements, and won without much resistance. Michigan's Proposal B was defeated even more spectacularly, for similar reasons. Both these campaigns were lost as soon as they were begun because of the political strategies adopted early on by reformers who failed to foresee the effectiveness of the opposition campaign.

Moreover, to harness the power of popular support, it is necessary to organize and raise money—lots of it. Although the mechanics of day-to-day political campaigning are well beyond the scope of this chapter, suffice it to say that during the twelve to eighteen months after a campaign goes public but before paid media advertising starts, it is necessary to engage all the professional political strategies to preserve, if not expand, support among voters and institutional stakeholders—all of which is expensive work.

Finally, paid media was a factor in every reform campaign discussed in this chapter. The Catholic Church has funded opposition campaigns wherever death-with-dignity reform has been proposed, including in Oregon in 1994 and 1997. To skilled political observers, this should come as no surprise. The church's preferred strategy is to fund efforts to oppose reform but remain behind the scenes. At the height of any statewide ballot campaign, the church will rely on the hardest-hitting and at times most misleading political advertising imaginable,⁴⁴ rendering an underfunded, poorly organized, media-poor grassroots campaign defenseless.

Seen in historical perspective, the current reform movement is making steady progress, but it is still in its infancy. The ten years between the first effort to legalize physician-assisted death with Washington's Initiative 119 in 1991 and the defeat of Hawaii's House Bill 2487 in 2002 is emerging as a pivotal time, during which there has been a sea change in the approach to death-with-dignity reform. The 1994 and 1997 victories in Oregon are very real, and the data emerging from Oregon rebut every political and clinical argument advanced by opponents of physician-assisted death. When the Oregon success is combined with the near successes on the Maine ballot in 2000 and in the Hawaii

legislature in 2002, one can see the potential of the current movement toward reform. With the right ownership of the issue, proper balancing of the competing public policy concerns, and smart political strategies, death-with-dignity reform can and will succeed in the years to come.

Notes

1. Oregon Death with Dignity Act, *Oregon Revised Statutes*, secs. 127.800–127.995 (1995).
2. See, for example, *ibid.*, sec. 127.815.
3. P. Goodwin, “Findings from Post-Election Survey,” GLS Research memorandum, Post-election survey of 600 Oregon voters, January 7–12, 1998; Oregon Death with Dignity State PAC Endorsement (2002), on file at Oregon Death with Dignity Political Action Fund, Portland; D. Hamilton, “Election 2002: Back Talk—Talk Back,” *Portland (Ore.) Tribune*, October 4, 2002, A4; Oregon Right to Die PAC Endorsement (1996), on file at Oregon Death with Dignity Political Action Fund, Portland; J. Kitzhaber, “Congress’s Medical Meddlers,” *Washington Post*, November 1, 1999, A21; S. Wolfe, “Candidate Bradbury Stumps in Ashland,” *Daily Tidings* (Ashland, Ore.), October 1, 2002, 1; R. Edwards, telephone interview with author, Salem, Oregon, September 19, 2003.
4. Oregon Right to Die PAC Endorsements (1998), on file at Oregon Death with Dignity Political Action Fund, Portland; “David Wu on Health Care: Voted No on Banning Physician-Assisted Suicide,” On the Issues, www.issues2000.org/House/David_Wu_Health_Care.htm (accessed March 4, 2004); “Blumenauer Testifies Against Proposed Legislation on Assisted Suicide,” press release, July 14, 1998, www.house.gov/blumenauer/press_releases/pro51.htm (accessed March 4, 2004); “Walden Opposes Effort to Overturn Will of Voters: Keeps Commitment to Uphold Oregon Law on Assisted Suicide,” press release, October 26, 2000, walden.house.gov/press/releases/2000/oct/pr102600.html (accessed March 4, 2004); “Darlene Hooley on Health Care: Voted No on Banning Physician-Assisted Suicide,” On the Issues, www.issues2000.org/House/Darlene_Hooley_Health_Care.htm (accessed March 4, 2004); “DeFazio Blasts House Vote on Assisted Suicide: Remains Hopeful About Chances for Defeat in Senate,” press release, October 27, 1999, www.house.gov/defazio/102799HCRelease.shtml (accessed March 4, 2004); “Standing Alone, Senator Wyden Kept the United States Senate from Overturning Oregon’s Twice-Passed Ballot Measure Legalizing Physician-Assisted Suicide,” wyden.senate.gov/meet/bio/pas.html (accessed March 4, 2004); S. Power, “Smith Backs Suicide Repeal,” *Statesman Journal* (Salem, Ore.), April 26, 2000, 1A.
5. Oregon Right to Die PAC Endorsement (2000), on file at Oregon Death with Dignity Political Action Fund, Portland; “Attorney General Hardy Myers to Take Legal Action to Protect Oregon’s Physician-Assisted Suicide Law,” State of Oregon Department of Justice media release, November 6, 2001, www.doj.state.or.us/releases/rel110701.htm (accessed March 4, 2004).
6. See 2002 candidate surveys, on file at Oregon Death with Dignity Political Action Fund, Portland.

7. P. Goodwin, "A Survey of Voters in Oregon on Issues Related to Measure 16," GLS Research memorandum (on survey of six hundred registered Oregon voters conducted April 20-27, 1997); memo dated "April, 1997."

8. J. Lyon, "Gubernatorial Candidates Tackle Issues at Forum," *Bulletin* (Bend, Ore.), April 18, 2002, A1; N. Budnick, "For GOP, Suicide Ain't Painless," *Willamette Week* (Portland, Ore.), December 5, 2001, 11.

9. Mellman Group, "Oregon Statewide Survey," February 2002, 5, on file at Oregon Death with Dignity Political Action Fund, Portland.

10. Gallup Poll, survey of approximately fifteen hundred U.S. adults, June 6-11, 1947, Gallup Organization.

11. Gallup Poll, survey of 1,544 U.S. adults, July 6, 1973, Gallup Organization.

12. Roper Organization Poll, survey of 1,982 U.S. adults, February 1998, Roper Center for Public Opinion Research.

13. Gallup Poll, survey of 1,018 U.S. adults, November 15-18, 1990, Gallup Organization.

14. Harris Poll, survey of 1,254 U.S. adults, November 11-15, 1993, Harris Interactive.

15. Gallup Poll, survey of 1,010 U.S. adults, April 9-10, 1996, Gallup Organization.

16. P. Goodwin, "Key Survey Findings," GLS Research memorandum (on survey of four hundred Maine voters, June 3-7, 1998), June 17, 1998.

17. QMark Poll, survey of four hundred Hawaii voters; "Death with Dignity 2002," February 1-4, 2002.

18. QMark Poll, survey of five hundred Hawaii residents, "Omnibus Study" January 28-February 1, 2003; Macro International Poll, survey of four hundred Vermont voters; "Vermont Poll," results reported February 28, 2004.

19. F. Solop, "Grand Canyon State Poll," Social Research Laboratory, Northern Arizona University, March 14, 2003 (survey of four hundred Arizona voters, March 6-11, 2003).

20. P. Goodwin, "National Voter Research Findings: Attitudes Regarding the Terminally Ill," GLS Research memorandum, July 17, 1998 (on survey of one thousand U.S. adults, July 8-13, 1998).

21. *Ibid.*

22. H. Taylor, "2-1 Majorities Continue to Support Rights to Both Euthanasia and Doctor-Assisted Suicide," Harris Interactive, January 9, 2002 (survey of 1,011 U.S. adults, December 14-19, 2001).

23. The Initiative and Referendum Institute provides a thoughtful explanation of the initiative process at www.iandrinstute.org.

24. Roughly two months before the November ballot, 59.5 percent of California voters answered yes to the following question: "From what you have seen, read or heard about Proposition 161, would you be inclined to vote yes or no on Proposition 161?" *The California Poll 92-06*, Field Institute, September 1992 (survey of 1,067 California voters, September 8-15, 1992).

25. Oregon Death with Dignity Act, sec. 127.880.

26. Hawaii State Legislature, 2002 sess., HB 2487 HD1, February 23, 2002, www.capitol.hawaii.gov/session2002/status/HB2487.asp (accessed March 4, 2004); Hawaii State Legis-

lature, 2002 sess., HB 2487 HD1, March 7, 2002, www.capitol.hawaii.gov/session2002/status/HB2487.asp (accessed March 4, 2004).

27. Hawaii State Legislature, 2002 sess., HB 2487 HD1, April 30, 2002, www.capitol.hawaii.gov/session2002/status/HB2487.asp (accessed March 4, 2004).

28. K. Rosati, "Physician Assisted Suicide—Victory for Now," *Hawaii Family Forum* 2, no. 5 (2002): 1–3, hawaiifamilyforum.org/newsletters20020510.pdf (accessed March 4, 2004); L. Benoit, "State Senate Rejects Physician-Assisted Suicide Bill on Final Day of Session," *Hawaii Catholic Herald*, May 10, 2002; E. Christian, "Legislative Report: Defeat of Physician Assisted Suicide a Victory for Conference," *Hawaii Catholic Herald*, June 7, 2002; Hawaii State Legislature, 2002 sess., HB 2487 HD1, May 2, 2002, www.capitol.hawaii.gov/session2002/status/HB2487.asp (accessed March 4, 2004).

29. Oregon Death with Dignity Act, sec. 127.880.

30. *Ibid.*, sec. 127.805.

31. *Ibid.*

32. D.E. Meier, C.A. Emmons, S. Wallenstein, T.E. Quill, R.S. Morrison, and C.K. Cassel, "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States," *New England Journal of Medicine* 338 (1998): 1193–1201.

33. Oregon Death with Dignity Act, secs. 127.815, 127.820, 127.830, 127.840, 127.850, 127.810, 127.897.

34. *Ibid.*, secs. 127.855, 127.865.

35. *Ibid.*, sec. 127.860.

36. Contribution data collected from public records held by the Washington State Public Disclosure Commission, 1991 Washington State Initiative 119 (election date November 5, 1991).

37. Contribution data collected from public records held by the State of California Fair Political Practices Commission, 1992 California Proposition 161 (election date November 3, 1992).

38. Contribution data collected from public records held by the Oregon Secretary of State's Office, 1994 Oregon Measure 16 (election date November 8, 1994).

39. Contribution data collected from public records held by the Oregon Secretary of State's Office, 1997 Oregon Measure 54 (election date November 4, 1997).

40. Contribution data collected from records held by the Michigan Secretary of State's Office, 1998 Michigan Proposal B (election date November 3, 1998).

41. Contribution data collected from public records held by the Maine Commission on Governmental Ethics and Election Practices, 2000 Maine Question 1 (election date November 7, 2000).

42. Rosati, "Physician Assisted Suicide—Victory for Now"; Benoit, "State Senate Rejects Physician-Assisted Suicide Bill on Final Day of Session"; Christian, "Legislative Report"; Hawaii State Legislature, 2002 sess., HB 2487 HD1, May 2, 2002.

43. This conclusion is based on a 1992 conversation with grassroots volunteer Jean Gillett.

44. M. Goad, "HMO Protests Prompt TV Stations to Pull Ad," *Press Herald* (Portland, Maine), November 2, 2000, 1A.