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KURT DARR

Assistance in Dying: Part II. Assisted Suicide in the United States

This Nexus is the second of a three-part series that considers assistance in dying, of which physician-assisted suicide (PAS) and euthanasia are the most prominent types. Part I outlined concepts, provided definitions, and described developments in Western Europe, especially in the Netherlands, as paradigmatic of the possible evolution of assistance in dying in the United States. Part II considers the legal context of assistance in dying in the United States and its present status. Oregon is given special attention because it remains the only state with legally sanctioned assistance in dying. Part III will consider the ethical and legal issues that assistance in dying raises for managers of health services organizations (HSOs) and their physicians. The need for private (non-governmental) HSOs to have a well-developed organizational philosophy and value system that prospectively consider how they will respond to legal developments that permit assistance in dying is obvious.

Kurt Darr is professor of hospital administration in the Department of Health Services Management and Policy, The George Washington University, Washington, DC, and an executive editor of *Hospital Topics*.
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The Work of Dr. Death

In 1990, one type of assistance in dying, PAS, became a prominent ethical and legal issue in the United States when it was thrust into the public's consciousness. Janet Adkins was 54 years old and suffered from the early stages of Alzheimer's disease. She feared losing her memory and the ability to engage in normal activities and sought the help of Dr. Jack Kevorkian, a retired pathologist, to assist her in committing suicide before her mental abilities became so impaired that she could no longer make a rational decision (Cohn 1990). Kevorkian had gained national prominence earlier that year at a press conference by showing a device of his design that enabled persons who wanted to die to self-administer toxic chemicals, after initial assistance from a physician. Kevorkian's help to Adkins was criticized as procedurally flawed, and Adkins's mental competence was questioned because of her diagnosis (Gibbs 1990). The case starkly focused the public's attention on active, voluntary euthanasia and the "right" to assisted suicide.

In several early assisted suicides, Kevorkian played an active role by starting a saline IV, after which the

patient initiated the flow of barbiturates and potassium chloride that caused death. Kevorkian's role changed as he continued to assist in suicides. After his medical license was revoked, Kevorkian, or "Dr. Death" as his critics called him, could no longer legally obtain the chemicals he had previously used. Therefore, he began by using carbon monoxide, which was breathed through a mask placed on the face of the patient, who then initiated the flow of gas. Kevorkian began videotaping conversations with "patients" held prior to assisting their suicide in which they answered questions that documented their state of mind as well as their desire to die. By the end of 1996, Kevorkian had assisted in more than 40 suicides. All his assisted suicides occurred in Michigan, which initially had no law banning it. Hastily passed legislation that outlawed assisted suicide did not stop him, and he continued to assist in suicides.

The numerous criminal proceedings against Kevorkian for assisting in suicide were unsuccessful for various reasons: The Michigan court of appeals ruled that the ban on assisted suicides was passed illegally; judges dismissed charges against Kevorkian,

ruling that assisted suicide is a constitutional right; and juries acquitted him (*Frontline* 2003). Kevorkian was finally convicted of second-degree murder in 1998, a verdict substantially based on a videotape that he made showing him administering a lethal injection to a Lou Gehrig's disease (amyotrophic lateral sclerosis [ALS]) sufferer. Kevorkian called it a mercy killing (euthanasia); prosecutors and a jury disagreed. He was convicted of second-degree murder and sentenced to a term of 10–25 years in prison.

By his own count, Kevorkian assisted in at least 130 suicides (*Wired News* 2003). Of 69 persons known to have died with Kevorkian's assistance or intervention, only 25% had been diagnosed as terminally ill (Brody 2001). That the majority of Kevorkian's "patients" were apparently not terminally ill, but instead were suffering from various chronic or degenerative diseases and whose mental state was unknown, raises significant ethical issues. Kevorkian was criticized on professional and ethical grounds, including assertions that he: did not know his "patients," was unqualified to diagnose or understand illnesses because he is a pathologist, had a conflict of interest because of his desire to publicize himself and (initially) his suicide machine, assisted persons who did not have terminal illnesses, and made little effort and was not qualified to judge the mental competence of the persons he assisted in suicide. Kevorkian hoped to establish an *obitorium*, a clinic where terminally ill persons wanting to commit suicide could be assisted to die.

One of Kevorkian's stated goals was to test the limits of patient autonomy. His primary defense was that the law criminalizing assisted suicide is an unconstitutional interference to a person's right to privacy. This defense used reasoning similar to that in *Roe v. Wade*, the U.S. Supreme Court deci-

sion that found that a constitutional right to privacy protected a woman's decision to abort her pregnancy in the first trimester from state interference. Assisted suicide presents an even stronger case for individual autonomy as expressed in the right to privacy because no other life (i.e., a fetus) is involved. Experts disagree on the constitutionality of assisted suicide, however (Kamisar 1993; Sedler 1993).

Dr. Kevorkian was unsuccessful in numerous appeals to the supreme court of Michigan. Similarly, Kevorkian could not gain U.S. Supreme Court review of various aspects of his involvement in PAS and subsequent criminal prosecution and conviction. For example, in mid-1995, the Court declined to review the 1994 Michigan supreme court's determination that there is no constitutional right to assisted suicide (Right to Life of Michigan 2004). His petition for a writ of *certiorari* from a ruling of the Michigan court of appeals denying his request for a new trial on his criminal conviction was denied by the Court in 2002 (*Kevorkian v. Michigan* 2002). At this writing, the Michigan parole board has approved Kevorkian's release for June 1, 2007, after serving eight years. He has promised not to assist in more suicides (Gray 2006).

Suicide and HSOs: The Case of Elizabeth Bouvia

Background. In late 1983, a dramatic case that highlighted several of the concepts surrounding assistance in dying began in California. Twenty-six-year-old Elizabeth Bouvia, who suffered from cerebral palsy, entered county-owned Riverside General Hospital and asked that the staff aid her in fasting until she died. Bouvia was not terminally ill, but she was unable to move and required assistance in all physical activities. She wanted the hospital to provide hygienic care and the drugs necessary

to give her a painless death by starvation. A court injunction prevented the hospital from discharging her. To ensure adequate nutrition, hospital staff inserted a nasogastric tube, allegedly against her wishes. She asserted that she had reached a competent and rational decision, one her lawyer argued was protected by the constitutional right to privacy and self-determination. Her mental competence was confirmed by several psychiatrists.

After a hearing on whether the hospital could be forced to assist Bouvia in her suicide, the court ruled that "despite her right to commit suicide, which is not illegal in California, she could not ask society in the person of the hospital staff to help her because she was not a terminal patient" (Matthews 1983, A3). Notably, California has criminal penalties against aiding and abetting a suicide. The court distinguished Bouvia from those with terminal illnesses. In January 1984, the California supreme court refused to hear her appeal (*Washington Post* 1984).

The decision permitted the hospital to force-feed Bouvia. She was discharged from Riverside General Hospital on April 7, 1984, and was hospitalized in Tijuana, Mexico (*New York Times* 1985). It was reported that she had reconsidered her demand to die and would return to the United States for medical treatment. Her lawyer maintained that she still wished to die, despite the fact that she had been accepted for care somewhere in California on the condition that she not stop eating (*Hastings Center Report* 1985).

After a year in the new institution and a subsequent stay of several months at an acute care hospital, where a morphine pump was installed for pain control, Bouvia was admitted to Los Angeles County-High Desert Hospital in late 1985. As at Riverside General Hospital, and

against her wishes, the staff inserted a permanent feeding tube. Court action by Bouvia initially resulted in the court's refusal to order discontinuation of the forced feeding. On appeal, however, the case was remanded, with instructions to consider her request further. As a result, tube feeding was discontinued and Bouvia was discharged. Her attorney stated, "She's promised to continue to eat her liquid diet. I know she would welcome death . . . but she has renounced [suicide]" (*Washington Post* 1986a, A12). In May 1986, she was hospitalized at Los Angeles County University of Southern California Medical Center, where she was treated for chronic pain (*Hospital Week* 1986). In June 1986, the California supreme court affirmed a lower court decision allowing her to die by refusing force-feeding (at the time she was accepting a liquid diet). The hospital had argued that removing the tube would officially endorse suicide (*Washington Post* 1986b). Since then, she has shunned publicity. Elizabeth Bouvia was last reported alive in 2002 (Coleman 2002).

Ethical and legal considerations. In addition to highlighting the problems of the nonterminally ill, the Bouvia case delineates the clash between organizational philosophy (here, with both ethical and legal justification) and patient autonomy. Bouvia's problem was not that the HSOs in which she was treated refused to discharge her; rather, it was difficult to find a facility that would admit her. Those that agreed to admit her insisted on doing everything they could to maintain or improve her physical condition—thus the force-feeding—which would be the natural propensity of the organization and which will almost certainly be consistent with its values and mission.

A number of state courts have addressed this issue. All states recognize that competent persons have the

right to forego medical treatment of any kind, including artificial hydration and nutrition through tube feeding. Similarly, all states recognize that mentally incompetent persons have the right to have a previously expressed wish regarding medical treatment followed, regardless of condition or prognosis. Differences lie, however, in the evidence required to establish a person's wishes in the circumstances extant (Hoefler 2007).

The Bouvia case suggests the limit of what patients can legally (and ethically) ask of HSOs. As shown by Bouvia, the law determines what the organization and its managers can do; the obligation to obey the law is minimum performance. The ethics reflected in the organization's philosophy determine the extent to which it uses a higher standard. State laws vary. Such differences reinforce the HSO's need to understand state law and, more important, to address issues such as those raised by Kevorkian and Bouvia prospectively within the context of its organizational philosophy.

If assistance in suicide becomes legal in more states, which would strongly suggest that it has gained much greater social acceptability, HSOs and their managers will have to address the ethical issues it raises. Nursing facilities, hospices, and acute care hospitals have many patients who have degenerative neurological diseases, are in a persistent vegetative state, or are terminally ill.

It is unlikely that the ubiquitous conscience clause will be overridden by laws that legalize assistance in suicide; as described later, this has not happened in Oregon. Conscience clauses protect personal and institutional providers who refuse to provide services, such as abortion, that they find morally repugnant. The conscience clause exception reinforces the need for HSOs to prospectively and specifically address the issue of

end-of-life treatment in their values statements. A well-established, clearly enunciated position lends credence to the organization's position. In developing their values statement, it is likely that most HSOs will take into account patients' rights and reasonable expectations.

Perhaps the most important reason for traditional HSOs to decline to assist in suicide is that the public will find it fearsome and inconsistent that providers whom they are asked to trust to help them regain and maintain their health also assist in suicide. The public may begin to distrust such providers because their role at any one time may be unclear. This suggests that establishing specialized facilities—as evidenced by Kevorkian's obitorium—and even commercialized assistance in suicide, are within the realm of possibility.

Legal Aspects of PAS

Initiatives to legalize PAS were considered in Washington state (Nightingale Alliance 1991) and California (Nightingale Alliance 1992). Both were rejected. In 1994, Oregon voters narrowly (52% to 48%) approved an initiative to enact PAS, in the Death with Dignity Act (DWDA). Court challenges delayed implementation. The Oregon legislature asked voters to repeal the law, a request that was soundly defeated (60% to 40%). PAS became available for terminally ill Oregonians in late 1997.

As of 2007, only Oregon has legalized PAS. In addition to Washington and California, unsuccessful attempts to pass PAS (or euthanasia) laws have been made in Michigan and Maine (Earll 2001). Similar legislation has been considered in more than a dozen other states (Lisko 1998). Statutes in 39 states criminalize assisted suicide; in six states the common law achieves the same purpose. Four states have neither statutory nor common law prohibitions against assisted suicide

(Longwood University 2004). This legal context is inconsistent with polls showing that a large majority of Americans favor physician help in ending the lives of the terminally ill.

In March 1996, the California-based federal Ninth Circuit Court of Appeals ruled in *Washington v. Glucksberg* (1997) that the Washington state law making physician-assisted suicide a felony was a denial of due process of law under the 14th Amendment to the U.S. Constitution. Its reasoning relied heavily on the Supreme Court's abortion cases, which it found to have compelling similarities (Weinstein 1996). A month later, the New York-based federal Second Circuit Court of Appeals ruled in *Vacco v. Quill* (1997) that terminally ill people have the same right to hasten death by taking drugs as they do by refusing artificial life support, thus striking down a New York state law. Its ruling was based on the Equal Protection Clause of the 14th Amendment to the U.S. Constitution (Biskupic 1996).

In 1997, the U.S. Supreme Court agreed to hear appeals of these two cases. A unanimous Court ruled in *Washington v. Glucksberg* (1997) and *Vacco v. Quill* (1997) that states may ban assisted suicide without violating either the Due Process or Equal Protection Clauses of the 14th Amendment to the U.S. Constitution, respectively. The Court did not decide whether states could pass laws permitting assisted suicide.

A collateral attack on Oregon's PAS law was launched in 2001 by then U.S. Attorney General John Ashcroft. Ashcroft issued an interpretive rule to address the implementation and enforcement of the Controlled Substance Act (CSA) of 1970 with respect to the Oregon PAS law. The rule declared that using controlled substances to assist suicide is not a legitimate medical practice and that dispensing or prescribing them for that purpose is unlawful. The inter-

pretive rule was challenged and a federal district court permanently enjoined enforcement. The Ninth Circuit Court of Appeals invalidated the rule, reasoning that by making a medical procedure authorized under Oregon law a federal offense, the rule altered the balance between the states and the federal government without the requisite clear statement that the CSA authorized the action; and in the alternative that the rule could not be squared with the CSA's plain language, which targets only conventional drug abuse and excludes the attorney general from medical policy decisions.

The U.S. Supreme Court issued a writ of *certiorari* and in September 2005 heard oral argument on the effort to prosecute Oregon physicians under federal law for prescribing excessive amounts of barbiturates and opiates to provide a lethal overdose for patients seeking PAS. In January 2006, the Court handed down its opinion that affirmed the Ninth Circuit decision in *Gonzales, Attorney General, et al. v. Oregon et al.* (2005). Writing for the Court and joined by five of his colleagues, Justice Anthony Kennedy determined that the CSA does not allow the attorney general to prohibit doctors from prescribing regulated drugs for use in physician-assisted suicide under state law permitting the procedure. Thus, at least at mid-2007, Oregon's PAS had met another challenge and PAS remains firmly a state purview.

The Oregon Experience

Background. Oregon law allows physicians to prescribe, but not administer, medications that can be used to end life. To request a prescription for lethal medications, a person must be: an adult (aged 18 years or older), a resident of Oregon, capable (defined as able to make and communicate healthcare decisions), and diag-

nosed with a terminal disease that will lead to death within six months (Oregon Department of Human Services 2006). Having met that threshold, a series of steps must be followed to receive the prescription:

The patient must make two oral requests to his or her physician, separated by at least 15 days.

The patient must provide a written request to his or her physician, signed in the presence of two witnesses.

The prescribing physician and a consulting physician must confirm the diagnosis and prognosis.

The prescribing physician and a consulting physician must determine whether the patient is capable.

If either physician believes the patient's judgment is impaired by a psychiatric or psychological disorder, the patient must be referred for a psychological examination.

The prescribing physician must inform the patient of feasible alternatives to assisted suicide, including comfort care, hospice care, and pain control.

The prescribing physician must request, but may not require, that patients notify their next-of-kin of the prescription request (Oregon Department of Human Services, 7-8).

The original law was amended in 1999 to require that pharmacists be informed of the prescribed medication's ultimate use. The physician may attend the patient when the medication is taken, but it is not legally required (Oregon Department of Human Services). Physicians must report all prescriptions for lethal medications to the state department of health services; physicians are protected from criminal prosecution if they adhere to the requirements of the law. Recognizing the moral issues raised by PAS, the law places no legal obligation on physicians, pharma-

cists, and healthcare systems to participate. The law specifically prohibits *euthanasia*, which is defined as someone directly administering a medication to end another's life (Oregon Department of Human Services).

Results. The first suicide under the Oregon law was reported in March 1998 (Booth 1998). The Blue Cross and Blue Shield plans of Oregon began covering PAS in early 1998 (AHA News 1998a). In late 1998, the Oregon Health Plan (which covers Medicaid patients) added PAS to end-of-life comfort care services such as pain medication and hospice (AHA News 1998b). By the end of 2005, 246 Oregonians had been assisted in suicide (Oregon Department of Human Services 2006).

Patient characteristics. Physicians reported in 2005 that their patients who chose PAS were concerned about a decreasing ability to participate in activities that make life enjoyable, the loss of dignity, and losing autonomy (Oregon Department of Human Services 2006). The 2005 report found no statistically significant differences between Oregonians who used PAS in 2005 and those from previous years.

Males and females were equally likely to take advantage of the DWDA. Divorced and never-married persons were more likely to use PAS than married and widowed residents. A higher level of education has been strongly associated with the use of PAS; Oregonians with a baccalaureate degree or higher were 7.9 times more likely to use PAS than were those without a high school diploma. Conversely, several groups have emerged as being less likely to use PAS. These include people aged 85 or older, people who did not graduate from high school, people who are married or widowed, and Oregon residents living east of the Cascade Range (Oregon Department of Human Services 2006, 12). Patients afflicted with

ALS, HIV/AIDS, or malignant neoplasms were more likely to use PAS. In 2005, all those who used PAS had some form of insurance and 92% were enrolled in a hospice (Oregon Department of Human Services).

That those who sought PAS under the Oregon statute in 2005 tended to be better educated, insured, and almost always in hospice care should allay fears that the law will be used primarily by poor, uneducated, mentally ill, or socially isolated Oregonians. This may not assuage the fears of those who already feel disadvantaged in society—including some ethnic groups and low-income and poorly educated people—and thus vulnerable to potential abuse of PAS, if, for example, it evolves as in the Netherlands toward active, involuntary euthanasia. The elderly and those with severe chronic and degenerative diseases may believe that they have a unique level of risk because they are most likely to feel the effects of an expressed or implied utilitarian calculus that will value their lives as less worthy.

Physician characteristics. In 2005, 39 Oregon physicians wrote 64 prescriptions for lethal doses of medication (Oregon Department of Human Services 2006). Prescribing physicians had been in practice a median of 26 years. Physicians in family medicine (62%), oncology (23%), and internal medicine (10%) were the most likely to write lethal prescriptions (Oregon Department of Human Services). During the first three years PAS was legal, physicians were present at the patient's ingestion of lethal medication half or more of the time. In 2005, however, the prescribing physician was present for only 23% of deaths. In 2005, the Oregon Board of Medical Examiners reviewed four cases: one involving witnessing of signatures and three involving failure to file required documentation in a timely

manner (Oregon Department of Human Services).

Summary. In its 2005 annual report, Oregon's Department of Human Services noted that a request for PAS can be an opportunity for a medical provider to explore patients' fears and wishes about end-of-life care and make them aware of other options (Oregon Department of Human Services 2006). Few complications have been reported from Oregon's assisted suicides, a result inconsistent with data from the Netherlands that were discussed in Part I. Complications reported in 2005 involved two patients who regurgitated the medication and one patient who regained consciousness after an initial period of unconsciousness (Oregon Department of Human Services).

One conclusion of the findings in Oregon is that physicians are using the law prudently and cautiously. Other explanations are possible, however. For example, the fact that few physicians were present (and emergency services were not called) when patients took the lethal medication may understate the complication rate and, subsequently, the pain and difficulty of dying encountered by patients. The findings may also suggest a high level of tentativeness on the parts of both physicians and those who might seek assistance in suicide—tentativeness that is likely to diminish over time and as PAS becomes more common and more socially acceptable. Given the evolution of PAS in the Netherlands, this latter explanation has merit.

Generally, opiates such as morphine are the drugs most often given to help patients die (Haney 1998). It is notable that in 1998, Oregon led the nation in medical use of morphine, an increase of more than 70% since 1994 when voters approved the first assisted-suicide referendum (Claiborne 1998). In 2005, the Oregon Depart-

ment of Human Services (2006) reported, however, that barbiturates are the medication of choice in PAS; morphine is used infrequently. Heavy use of morphine in Oregon suggests reliance on it for palliation. Passage of the original law stimulated Oregon physicians to improve care of the dying (Ganzini et al. 2001). Most major hospitals in Oregon have established strong pain management programs to give patients an alternative to assisted suicide (Baron 1999).

Summary

In mid-2007, it seems clear that state laws prohibiting assistance in suicide will not fall to a challenge on the basis of the U.S. Constitution. Oregon's Death with Dignity Act stands alone on the United States legal landscape. The results of PAS in Oregon will be analyzed by observers and used as a template for jurisdictions considering similar legislation. Given the opinion surveys showing strong public support for assistance in dying for the terminally ill, the issue is just below the surface, and it will likely come to the fore again. Assistance in dying and assisted suicide will be an issue for HSOs and their physicians and staff. The organizational philosophy and value system regarding assistance in dying should be addressed early and enunciated clearly, lest the HSO find itself ill-prepared to respond to this critical issue.

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