Mortality,
February 2005; 10(1): 23 – 41

Routledge
Taylor & Francis Group

Physician-assisted suicide and the politics of problem definition

JOHN M. STRATE[1], MARVIN ZALMAN[2], & DENIS J. HUNTER[3]

[1]*Department of Political Science, Wayne State University, Detroit, MI, USA,* [2]*Department of Criminal Justice, Wayne State University, Detroit, MI, USA, and* [3]*Criminal Justice, Wayne State University, Detroit, MI, USA*

Abstract
In the United States the issue of physician-assisted suicide (PAS) first reached the governmental agenda in the state of Michigan. This occurred because of the personal crusade of Dr Jack Kevorkian, a retired pathologist, to legalize PAS. In June 1990 Kevorkian initiated his crusade by assisting Janet Adkins, who suffered from Alzheimer's disease, to commit suicide. The bizarre nature of the suicide—conducted in the back end of Kevorkian's Volkswagen van, and using a suicide machine to deliver a lethal dose of a drug, created an international media sensation. The efforts of prosecutors to stop Kevorkian were frustrated because Michigan, unlike most other states, did not have a law prohibiting assisted suicide. In response to the controversy, the Michigan state legislature enacted a temporary ban on assisted suicide and created the Michigan Commission on Death and Dying, charging it with developing legislative recommendations on aid-in-dying. The Commission, comprising 22 groups, is of historical interest because it was one of the first public bodies in the United States to debate the issue of PAS. The debate that occurred on the Commission illustrates three different definitions of physician-assisted suicide deriving from beliefs rooted in political ideology, moral intuitions and religious belief. It also illustrates that the politics of PAS for some time is likely to involve conflict over different problem definitions.

Keywords: *Physician-assisted suicide, problem definition*

Introduction

Physician-assisted suicide (PAS) is the most controversial of the right-to-die issues that have appeared on the governmental agenda (Glick, 1992; Glick & Hutchinson, 2001). In the United States the issue exploded onto the public agenda in June 1990 with media coverage of a bizarre story—Dr Jack Kevorkian's assistance in the suicide of Janet Adkins, a sufferer of Alzheimer's disease, in the back end of Kevorkian's Volkwagen van in a county park in metropolitan Detroit. Kevorkian had built a contraption using an IV that, once a patient activated it, would deliver a lethal drug. Legal action against Kevorkian was difficult because, unlike most other states, Michigan did not have a law prohibiting assisted suicide. After the Michigan state legislature did little in response to the Adkins suicide, and despite legal actions to stop him, Kevorkian resumed his forays into ''obitiatry.'' The actions of Kevorkian shocked many in the United States and in other countries who viewed them as

Correspondence: John Strate, Department of Political Science, Wayne State University, Detroit, MI 48202, USA. E-mail: jstrate@wayne.edu

ISSN 1357-6275 print/ISSN 1469-9885 online
DOI: 10.1080/13576270500030974

macabre. As he persisted, however, it became clear that he had touched a sensitive nerve regarding medical practice and public policy. What should doctors be allowed to do to help ease the suffering of terminally ill and, perhaps also, severely disabled patients who wanted help in dying? The importance of PAS as a public issue is seen in the intense medical, religious, legal, ethical and popular debate it has sparked, and in the fact that the issue quickly came before the United States Supreme Court (*Vacco v. Quill*, 1997; *Washington v. Glucksberg*, 1997).[1] Although the Court found no constitutional right to PAS, it recognized the legitimate role of state policy makers in addressing the profound questions raised by PAS, thus shifting the debate to state political fora.

In the United States, moral issues like PAS that reach the governmental agenda tend to stimulate unusually high levels of citizen participation (Hoefler & Kamoie, 1994; Clark, 1997; Fino *et al.*, 1997; Hoefler, 1997; Glick & Hutchinson, 2001).[2] Public opinion is important in determining policy content in most areas of morality policy (Fairbanks, 1977; Mooney & Lee, 1995, 2000; Haider-Markel & Meier, 1996). Advocacy coalitions in the United States supporting PAS have had public opinion on their side, with polls routinely showing a majority of the public to favor it (Glick & Hutchinson, 2001). To date, however, this public opinion advantage has not been sufficient to impress state policy makers, as legislatures have uniformly refused to follow majority public opinion and enact PAS. PAS advocates, failing in state legislatures and the courts, turned to the initiative process, but with only one success in Oregon, whose voters narrowly approved an assisted suicide measure that prevailed after a serious challenge. Aside from Oregon, PAS initiatives have failed in Washington, California, Michigan and Maine (Clark, 1997).

The failure of advocates to translate favorable public opinion into public policy is due in part to the nature of the debate that has occurred in state political arenas. Debate that occurs in public settings, having political goals, is likely to reflect, but have fewer nuances than, the intellectual debate that occurs in medical, religious, legal and ethical discourse. The political uses of public debate include putting a problem on the agenda or keeping it off; advancing and getting support for or defeating particular definitions of problems; expanding or narrowing the range of policy options that are considered; and securing or preventing the enactment of particular policies. To accomplish such purposes, argumentative complexity is likely to be a hindrance rather than a help (Dillon, 1993).

In the United States, PAS is an area of morality policy where organized interests—including the Catholic Church, medical associations and right-to-life groups—have dominated (Glick & Hutchinson, 2001). In public fora the quality of debate among all groups, as is demonstrated in this paper, has tended towards the hard lines of policy prescriptions rather than the more finely delineated discussions in the professional literature.

This paper examines the PAS debate in a state forum through the lens of alternative problem definitions. At the center of politics and policy development are disputes over answers to basic questions: What is the problem? Is it urgent? What should the government do about it? (Rochefort & Cobb, 1994). We show that in Michigan's public debate the complexities of PAS were simplified and channeled, through the formation of factions, into three contending problem definitions with their roots in three different belief systems.

Public debate involves attempts to persuade others. Ideally, persuasion, or the use of ideas or belief systems to motivate others to political action, is at the heart of democratic politics. As Deborah Stone (1997: 11) puts it: [the] "essence of policy making in political communities ... [is] the struggle over ideas. Ideas are a medium of exchange and a mode of influence even more powerful than money and votes and guns. Shared meanings motivate people to action and meld individual striving into collective action. Ideas are at the center of all political conflict. Policy making, in turn, is a constant struggle over the criteria for

classification, the boundaries of categories, and the definition of ideals that guide the way people behave.''

Opinions on questions of morality policy tend to be based upon non-negotiable ''first principles'' or basic values derived from moral intuitions, religious beliefs or political ideologies. As a result, participants in morality policy debates are unlikely to compromise. Although not contests for economic goods, a great deal is at stake in policy struggles over morality issues, as governmental policy decisions result in clear winners and losers, affirming the values of the winners and repudiating the values of the losers (Mooney, 2001). How problems are defined ultimately determines the policy decisions reached by government and the content of public policy.

The issue of PAS is international in scope. The reason is that problems in end-of-life medical care are common to all post-industrial societies. Populations are aging. Life-extending medical technologies such as antibiotics, artificial nutrition and hydration, cardiopulmonary resuscitation, chemotherapy, dialysis machines, respirators, and others are able to prolong the dying process far longer than was possible in the past. The result, for some patients, is loss of dignity and increased suffering. The debate over PAS, regardless of where it occurs, is thus over its appropriateness as an end-of-life option for some patients. Arguments relevant to this debate that occurred early on in Michigan have reappeared, and are likely to reappear, in other jurisdictions.

The Michigan Commission on Death and Dying

We examine the debate that occurred within the Michigan Commission on Death and Dying (MCDD), a body set up by the state legislature[3] more than two and a half years after Kevorkian's first assisted suicide in June 1990 to study issues related to PAS and to make recommendations. This and other study commissions were empanelled at that time (Annas, 1993; Brody, 1993; Persels, 1993; Fino *et al.*, 1997; Zalman *et al.*, 1997). The MCDD, however, unlike the New York Task Force on Life and the Law that was constituted as a body of individual experts (e.g. physicians, ethicists) with a loose link to public policy making, was more closely tied to the state legislature's agenda (New York State Task Force, 1994). The statute establishing the MCDD (1) required it to deliberate and submit recommendations to the state legislature within 15 months, and (2) created a felony with a four-year/$2000 fine sentence for intentionally providing the means or otherwise of assisting a suicide. The felony ban was set to expire six months after the Commission submitted its final report. This legislative activity was in large measure a result of public furor aroused by Kevorkian's activity in Michigan. As PAS reached the governmental agenda earlier in Michigan than in other states, the MCDD was one of the first legislatively established bodies to debate it, and thus the debate that occurred there is of historical interest.

The MCDD first met in June 1993, formally charged to study ''voluntary self-termination'' and to recommend a legislative response. Wording is important in policy making and the vague phrase, ''voluntary self-termination,'' allowed the Commission to consider both assisted suicide and euthanasia. Ultimately, the MCDD could not reach a consensus on whether to recommend legalization of PAS. Nevertheless, it did complete and send a four-part final report to the legislature in June 1994, with one section detailing areas of consensus (e.g. pain management) and the other sections presenting reports of the positions of three factions that emerged during the Commission's work (MCDD, 1994). These reports were entitled the Model Statute Report, the Procedural Safeguards Report and the Report Opposing Legalized Assisted Suicide.

The MCDD comprised 22 interest groups representing diverse views. These groups were selected through an open political process by which any secular association that wished was allowed to participate. The 22 groups included seven health care groups, four long-term care groups, three professional groups outside health care, three groups representing the disabled, two senior citizen groups and three civic groups.[4] Each group had one vote, appointed a delegate and an alternate, and the delegates cast votes for the groups they represented.

The 22 groups included most Michigan interest groups with a stake in the PAS question, although a few small disability groups did not ask to serve. Although the legislature deemed it inappropriate to invite religious groups to serve on the Commission, religious views were expressed either by delegates who represented other groups or by religious authorities themselves at public comment sessions. For example, Archbishop Adam Maida, leader of Michigan's Catholics, was the first person to address the Commission.

Delegates received substantial oral and written communications, with a considerable amount from the public. During time for public comment set aside at regular meetings, a total of 52 individuals spoke, including clergy, the disabled, hospice workers, right-to-life activists, nurses, physicians and right-to-die advocates. Additionally, outside experts addressed the Commission on PAS developments in the Netherlands and in the UK, on hospice care and on pain management.

For most of the 22 groups, delegates were formally or informally bound to directly represent the positions on PAS of their groups, regardless of their own personal views. A few groups that were neutral on the issue permitted their delegates to represent their own personal views before the Commission.

Sources of data and methodology

The data sources for this study include notes based upon direct observation of 11 regular MCDD meetings held in the state capital, Lansing, notes taken at a few special meetings held there, and notes taken at a public hearing held in Detroit (six were held overall at different locations throughout the state). Data sources also include personal, semi-structured interviews with 35 of the 44 delegates and alternate members of the 22 groups. We also relied on MCDD documents.

Our analysis relies mainly on qualitative assessment of notes and other Commission materials, supplemented by quantitative analysis of the interview and roll call data. The section below identifies the three problem definitions that emerged on the Commission and links them to differences of perspective in nine areas. The next section summarizes the politics of the Commission and its linkage to conflict over problem definitions. A final section analyzes votes on the Commission that reflected its deadlock on the issue of PAS.

Three problem definitions

In the course of debate, 16 of the MCDD's 22 groups coalesced into three distinct factions, each reflecting one of the three perspectives. Another six groups remained neutral. Each of the three factions had a favored policy solution based upon their understanding of the problems created or addressed by PAS.

The largest (by number of groups)—the personal autonomy faction—included delegates from nine groups[5] that favored legalizing PAS with restrictions. The problem to this faction was the absence of a law in Michigan that legalized and regulated assisted death. A few patients—such as terminally ill amytrophic lateral sclerosis (ALS; Lou Gehrig's disease) and

cancer patients—might experience unbearable suffering that could not be relieved by palliative care. Such patients should have the right to enlist the help of a physician to die. A law would provide legal protections to physicians giving end-of-life care; it would also stop the kinds of abuses that Kevorkian was alleged to have committed. Adults are presumed to be competent and their decisions to enlist the help of a physician to die should be respected and should be accompanied by only as much governmental regulation as is necessary to insure the efficacy of the process. This faction saw the problem as urgent because, regardless of what they thought about Kevorkian's methods, they agreed with him that there was a problem with the medical treatment of the terminally ill and severely disabled and that there were indeed a few patients who should have the right to enlist the help of a physician to die.

The disabilities faction included delegates from four groups[6] that opposed PAS, but in particular did not want any legal requirement for physician participation. Its position was that if PAS were to be legalized, any policy on voluntary self-termination had to have strong safeguards to protect vulnerable groups such as the aged and the disabled (including the chronically ill and mentally retarded). The problem to this faction was societal discrimination against vulnerable groups and the fact that government had not done enough either to eliminate the discrimination or remedy its effects. Members of vulnerable groups had reason to be fearful of physicians because of their control of medicine. Without strong safeguards, there was possibility of physician abuses. This faction saw the problem as urgent because, if physician-assisted death were legalized, there was danger of the ''slippery slope.'' This metaphor expresses the fear that once society accepts PAS (even under restricted conditions), what was once available to only a few will over time be extended to larger numbers. More dangerous, involuntary euthanasia may be deemed obligatory for those whom society regards as having too low a quality of life and who are too burdensome.

A third faction, the sanctity-of-life faction, included delegates from three groups[7] that opposed PAS under any circumstances. The problem for this faction was stopping Kevorkian who was killing human beings. The decision to commit suicide was nearly always irrational and due to a diagnosable illness such as depression. Society lacked respect for the intrinsic value of human life and was ready to rush to judgment about patients who appeared to have a poor quality of life. PAS amounted to killing and was a solution neither for mental illness nor for inadequate palliative care. The problem was urgent because PAS threatened traditional medical values. Kevorkian and the killing should be stopped by enacting a permanent ban on assisted suicide. There was need for improvements in medical education in the areas of pain management and end-of-life care.

Delegates from six groups, representing a quarter of the MCDD's votes, did not join a faction. Four groups were officially neutral on PAS but expressed concerns about governmental regulation,[8] while delegates from two neutral groups stated that government should keep out of the area although they would have aligned with the personal autonomy faction had their groups left them free to do so.[9]

We can use the interview data to compare the views of delegates from the different factions. We asked delegates whether they agreed or disagreed with five different arguments for aid in dying, and seven different arguments against aid in dying. Table I shows the number of members of each faction who agreed with each of these different arguments. The table shows that the degree of consensus was greatest among the 11 members of the personal autonomy faction. All of them agreed with four of the five arguments in favor of aid in dying. Two or fewer agreed with six of the seven arguments against aid in dying. There was less consensus among the seven members of the disabilities faction; five agreed with three arguments for aid in dying; six also agreed with two arguments against aid in dying. The

degree of consensus was fairly high among members of the sanctity-of-life faction, which numbered six. None of them agreed with two arguments for aid in dying; at least five members agreed with six of the seven arguments against aid in dying. Polarization of views was greatest between the personal autonomy and sanctity-of-life factions. Members of these two factions disagreed completely on the right of self-determination argument and almost completely with respect to four other arguments. Polarization between the personal autonomy and disabilities faction existed over the ''slippery slope'' and ''difficult or impossible to restrict the categories'' arguments. The disabilities faction, however, shared views similar to the sanctity-of-life faction on the ''some people will feel an obligation to die'' and ''slippery slope'' arguments.

Using our notes and the interview data described above, we can further elaborate on differences between the factions and their understandings of the problems created by or addressed by PAS in nine areas: death, desire to die, hastening the dying process, the meaning of human life, human nature, the severely disabled, physicians, pain management and government.

(1) *Ideas about control over death.* The personal autonomy and disabilities factions accept that death is natural and inevitable; however, its timing, perhaps by PAS, may be subject to human control. The sanctity-of-life perspective is distinctive and rooted in the Christian belief that God is sovereign, that life is a gift from God and that our lives belong to God. PAS is suicide and violates God's final authority with respect to taking life.

(2) *The desire to die.* The sanctity-of-life perspective is paternalistic—those who want to die must be protected from PAS and from making the wrong moral choice; the desire to die is irrational, caused by depression, pain or other kinds of suffering that require medical, including psychiatric, diagnosis and treatment. The disabilities perspective worries about a culture of death—psychological pressure on the terminally ill and severely disabled to choose death because of the financial and care-giving burdens they impose—and about the ''slippery slope.'' Society will take away the right of terminally ill and severely disabled persons to choose life. As Table I shows, six of the seven members of the disability faction agreed that ''some people will feel an obligation to die,'' and six of seven also agreed that it will ''result in a slippery slope.'' The personal autonomy perspective presumes that many who are terminally ill and severely disabled and who want to die have reached a rational decision based upon quality-of-life considerations; adults should enjoy a presumption of competence in making their own choices.

(3) *Pain and hastening the dying process.* The sanctity-of-life perspective cautiously approves of the use of drugs that relieve suffering, even though they may inadvertently hasten the dying process (i.e. the double effect). It strongly disapproves, however, of the use of drugs that simply hasten the dying process, likening their use to euthanasia, a euphemism for murder. The perspective is more accepting of suffering, because even for those who are dying, suffering has testing and educative functions. As Table I indicates, only two of six members of the sanctity-of-life faction agreed that it was ''cruel to refuse aid in dying.'' The disabilities perspective fears that safeguards may not be in place to ensure that a person's decision to hasten the dying process (e.g. through the use of drugs) is voluntary, consistent with their fear of the ''slippery slope.'' The personal autonomy perspective argues that hastening the dying process may be the only way to relieve unbearable pain and suffering. Those who are suffering, particularly those who are left with only this option, should be able to

Table I. The relationship between faction membership and agreement with arguments both for and against aid-in-dying, Michigan Commission on Death and Dying (1994).

	Number within faction in agreement and overall percentage in agreement				
	Personal autonomy	Disabilities	Sanctity of life	Neutral	Overall %
Arguments for aid-in-dying[a]					
Patients should have the right to choose aid-in-dying because of the right of self-determination	11 of 11	5 of 7	0 of 6	4 of 6	67
It is cruel to refuse aid-in-dying to terminally ill patients who are suffering intolerable pain	11 of 11	5 of 6	2 of 6	4 of 7	73
Patients whose quality of life is seriously and permanently impaired should be able to seek aid-in-dying	11 of 11	3 of 6	1 of 6	4 of 6	66
Pain management is not always effective	11 of 11	5 of 7	2 of 6	8 of 8	81
It will reduce health care costs	5 of 9	3 of 6	0 of 6	1 of 6	33
Arguments against aid-in-dying[b]					
Some people will feel an obligation to die—that is, pressure will be put upon the old, the sick and the disabled to seek aid-in-dying	6 of 10	6 of 7	5 of 6	4 of 8	68
It will result in the slippery slope—that is, aid-in-dying will eventually lead to involuntary euthanasia	2 of 11	6 of 7	5 of 6	4 of 8	53
It will diminish the value that society places on human life	2 of 11	2 of 6	6 of 6	2 of 8	39
It runs contrary to the goals of the health care professions	1 of 10	3 of 5	6 of 6	4 of 8	48
It is contrary to God's will	1 of 10	1 of 5	2 of 5	1 of 8	18
It will be difficult or impossible to restrict the categories of people who will be eligible to seek aid in dying	1 of 11	3 of 6	6 of 6	5 of 8	48
It would not be necessary if there were adequate pain management, hospice care, and home and health care services	1 of 11	2 of 6	5 of 6	3 of 8	35
Number of interviews[c]	$n = 11$	$n = 7$	$n = 6$	$n = 8$	$n = 31$

[a]Question: Opponents of the ''right to die'' have raised various arguments against aid in dying. Do you agree or disagree with these arguments?
[b]Question: Proponents of the ''right to die'' have raised various arguments for aid in dying. Do you agree or disagree with these arguments?
[c]Don't know and refusals were coded as missing.

choose it. As Table I shows, all members of this faction agreed that it was ''cruel to refuse aid in dying.''

(4) *The meaning of human life.* The sanctity-of-life perspective sees human life as sacred—a gift of God; because of this, society should never condone suicide; choosing suicide is a decision to disobey God. As Table I shows, only two members of this faction, however, agreed that aid in dying was ''contrary to God's will;'' it is possible that several were reluctant to admit religious reasons for their opposition to PAS. All six members of this faction did agree, however, that aid in dying would ''diminish the value society places on human life.'' The disabilities perspective emphasizes the right of each individual to claim meaning for her or his own life, regardless of what society might think about its quality. The personal autonomy perspective argues that the quality of life matters as much as its duration. As Table I shows, all 11 of the members of the personal autonomy faction agreed with aid in dying in situations where the ''quality of life was seriously impaired.''

(5) *Human nature.* The sanctity-of-life perspective takes the view that evil is inherent in an imperfect human nature and, if not curbed, will spread throughout society. Moral action is that which counteracts and roots out evil. The disability perspective on human nature is pessimistic: social relationships reflect asymmetries of power; people who wield power commonly act selfishly and often harm those without it; the disabled are relatively powerless and therefore have reason to mistrust others. The tendency of members of both the sanctity-of-life and the disability factions to agree that aid in dying will ''result in the slippery slope'' probably derives from their pessimistic views about human nature. Members of the sanctity-of-life faction were especially pessimistic, with all six agreeing that it would be ''impossible to restrict the categories of people eligible for aid in dying.'' The personal autonomy perspective on human nature is far more optimistic and sees humans as generally trustworthy and responsible.

(6) *Views about the disabled*. The sanctity-of-life perspective stresses the equality and dignity of all persons before God, regardless of their physical or mental disabilities. In the religious view, God is supreme; all persons are creations of God and equal before Him. The disability perspective argues that the disabled are vulnerable, subject to discrimination and in need of societal supports. Governmental intervention is essential if the disabled are to secure the independence enjoyed by others; to some extent, government acts as a surrogate parent and protector. The personal autonomy perspective, on the other hand, sees the disabled as deserving of special consideration because of their poor quality of life.

(7) *Views about doctors and the medical profession.* Such views are very important to understanding positions on PAS. The sanctity-of-life perspective asserts that doctors should be healers, not killers, and cites the Hippocratic Oath. Physicians possess the knowledge of what best promotes healing; their authority to use that knowledge supersedes patient autonomy. As Table I shows, all of the members of the sanctity-of-life faction agreed that aid in dying was ''contrary to the goals of the health care professions.'' The disabilities perspective is entirely different from the other two perspectives, expressing a visceral fear of doctors, reflecting a very pessimistic view of human nature. Doctors are powerful, even holding the power of life and death, and are potentially dangerous. The personal autonomy perspective, consistent with its more optimistic view of human nature, voices greater confidence in doctors, their professionalism and their desire to act in the patient's best interests. As Table I shows, only one member of the faction agreed that aid in dying was ''contrary to the goals of the health care professions.''

(8) *Pain management.* This was a central topic on the MCDD. There was agreement that doctors know much less than they should about pain management and use it less than they should. To a survey question about whether there was adequate training in the treatment of pain management, among all delegates, 88 percent answered "no." There was agreement that pain management is an important element of any solution to the pain experienced by some terminally ill and severely disabled persons. However, the sanctity-of-life perspective tends to see pain management, if used properly, as being almost always effective in relieving suffering; if pain management in combination with other comfort care is sufficient, then PAS is superfluous. As Table I shows, five of six agreed that aid in dying was "not necessary if there were adequate pain management, hospice care, etc." The disabilities perspective is often informed by personal experience with pain and therefore claims first-hand knowledge of the need for, limitations of, and collateral effects of pain medications. The personal autonomy perspective argues that pain management fails for a few conditions and thus is not sufficient. As Table I shows, only one of 11 agreed that aid in dying was "not necessary if there were adequate pain management, hospice care, etc." For all three perspectives there are few moral questions that arise from the use of pain management, except perhaps for the concern by the sanctity-of-life faction that medications not be used exclusively to hasten the dying process. There were also a few concerns about the problems of patient addiction.

(9) *Views about government and the right to self-determination.* The sanctity-of-life perspective holds that on moral issues the state's laws are subordinate to God's laws and ideally should support them. The disabilities perspective presumes the existence of positive rights for the disabled and the necessity for governments to protect and assure their realization. Thus, should PAS become legalized, government must play an active role in establishing, implementing and monitoring safeguards. The personal autonomy perspective, while recognizing limits to personal liberty and a need for governmental regulations to prevent abuses, fears burdensome government regulations that unnecessarily intrude upon privacy and self-determination; it assumes that adults are capable of making their own end-of-life decisions.

In the analysis that follows, we trace the way in which these constellations of ideas were used by delegates and factions to shape the outcome of the MCDD's votes and its report.

An analysis of Commission deliberations: The politics of problem definition

Delegates tried to control the MCDD's agenda and promote their own favored policy solutions by focusing the attention of fellow delegates on certain problems and not on others. In response to our survey, 63 percent of delegates said that they were very effective in getting their group's position before the MCDD, 29 percent somewhat effective, and only six percent not effective. Most delegates also felt that they had learned about the positions of other groups: 53 percent of the delegates responded a great deal, 9 percent quite a bit, 18 percent some, and 18 percent not much. The Commission thus gave interest groups a public forum in which to present their own positions and learn about other groups' positions. Several delegates, especially those from neutral groups, used the deliberations to express their personal opinions.

Delegates were not very successful in persuading other delegates about their views: 57 percent said they had not been able to persuade other members to their point of view and

only 37 percent said they had. When asked whether their own views had changed, 14 percent said a great deal, 6 percent quite a bit, 23 percent some, and 57 percent not much. The limited success of persuasion is consistent with the observation that individual preferences tend to be stable in policy deliberations (Jones, 1994). Participants in policy discussions typically try to identify the values of other participants, and then activate those values that will lead the participants to favored modes of thinking about problems and solutions, rather than seeking an outright change in values.

The Commission's first meeting was held after Kevorkian had assisted in 16 suicides of persons suffering from cancer, multiple sclerosis, ALS and other illnesses. The delegates' awareness that some seriously ill people in Michigan and from elsewhere had turned to Kevorkian was rarely stated but was salient to the MCDD's deliberations. The Commission very much operated in the shadow of Kevorkian's work; it is highly unlikely that the state legislature would have otherwise passed a law temporarily banning PAS and establishing a study Commission. It was Kevorkian who almost single-handedly put PAS on the governmental agenda in Michigan. Thus, the delegates' understanding of PAS involved questions such as: Why had people turned to Kevorkian? Were they rational, or were they suffering from depression? Why did they seek out a notorious PAS practitioner rather than find relief for their suffering in some other way? The disagreement between the factions as to the answers to these questions reflected their lack of consensus on problem definitions.

Personal autonomy faction

The personal autonomy faction supported PAS and saw little difference between a physician assisting a patient to commit suicide[10] and a physician taking the final action, with the patient's consent, that brings about death.[11] Its members emphasized personal choice in end-of-life decision making. PAS is necessary because existing treatments may not be effective or may be otherwise unacceptable. Its members reached agreement that only a mentally competent adult who has a terminal illness or a condition involving irreversible suffering may have access to PAS. For these persons, it is cruel for society to unduly interfere in personal end-of-life decisions.

This faction's leader repeatedly urged other delegates to see their task as formulating model legislation to help out the few for whom pain management was ineffective.[12] At a Detroit public hearing[13] and in other settings, he asked experts whether there were a few patients who could not be helped by pain management. A lawyer by training, a politician and a delegate of the state bar association, it is not surprising that he wanted to define the problem as narrowly as possible so that it would be amenable to a legal solution.

He also was impatient and tried several times, without much success, to control the direction and tempo of the Commission's work. For example, at the meeting of December 20, 1993, the first at which subcommittee reports were discussed, he startled other delegates by presenting a motion that the Commission recommend legalizing PAS. It was clearly premature, and a motion to table passed 12 to 5.[14]

Another member of this faction, a law professor, argued that personal autonomy, although not an absolute, was a ''prime directive'' for the Commission.[15] He distinguished between positive and negative rights. A right to seek aid-in-dying did not imply a corresponding obligation for a physician to provide such a service. He objected to efforts by other factions to control definitions. For example, at one meeting a delegate began talking about the danger of the slippery slope, and he retorted that the greater danger was the slippery slope of governmental intrusion into the personal lives of the terminally ill.[16]

Several members of this faction who belonged to health care professions indicated the support of their groups for the concept of patient self-determination, which precluded an absolute ban on PAS. A delegate of the American Civil Liberties Union argued repeatedly that our society presumes that adults are competent to make decisions for themselves in their own best interests.[17] Overall, the members of this faction displayed impatience with the Commission's progress. Their efforts to control its agenda, however, backfired as it angered members of other factions, who felt that their own opinions and those of the groups they represented had not been given an adequate hearing.

The personal autonomy faction led the effort to get majority support for legalization of PAS. Its product, the Model Statute Report, advocated allowing PAS with strict supervision. Such aid-in-dying[18] was not restricted to the terminally ill, but would be available to those with an irreversible, progressive, debilitating or degenerative disease, emanating from a physical condition, accompanied by unbearable or unacceptable suffering. Safeguards to prevent abuses included: two unrelated, disinterested persons had to record and witness requests; an attending physician had to determine eligibility and a consulting physician had to confirm it; consultations were also required with three specialists, including a psychiatrist or psychologist, a social worker, and an expert on pain management or a hospice professional to explore alternatives to aid-in-dying; the probate court would certify the process; the individual had to make two further requests for aid-in-dying with a waiting period of seven days between requests. Minors and incompetent persons were ineligible.

The Model Statute Report's extensive safeguards were in part based on the substantive policy views of members of the personal autonomy faction and in part designed to obtain an absolute majority of possible votes in favor of PAS (i.e. 12 of 22). At a meeting set aside to discuss the Model Statute Report, the committee's chair discussed various concerns addressed by the committee. On the issue of eligibility for PAS, the committee tentatively decided to limit it to the terminally ill, although there were strong feelings that individuals who suffered greatly from unalterable medical conditions should be eligible. There was also a concern that defining ''terminally ill'' as six months or less to live was arbitrary. The committee resolved the issue of whether a physician or a person of the patient's choosing should be present in favor of a physician being present. This requirement was challenged by the disability faction, but personal autonomy faction members believed that the presence of a physician was important for the efficacy of PAS and because PAS would not otherwise be accepted by the public and the legislature.

PAS opponents often cast about for arguments that might catch the attention of other delegates to get them to view this alleged ''solution'' in another way. For example, there was a question regarding patient privacy and autonomy. Was it practical to require a physician to be present? When a physician prescribes a drug, for example, the patient ordinarily takes it without supervision. Another question regarded patients turned down by physicians. Could such patients go ''forum shopping''?

Members of the personal autonomy faction, to attract support to their position, set limits on those who would be eligible for PAS to those ''mentally competent adults who have a terminal illness or a condition involving irreversible suffering.'' They recognized that personal autonomy was not an absolute value; nevertheless, government should avoid excessive intrusion into end-of-life decision making because the desire by such persons to bring an end to their suffering outweighed any governmental interest in preserving and protecting life. Their arguments included both positive and negative conceptions of liberty. A positive conception of liberty supports efforts by the community to make available to particular categories of individuals more end-of-life choices, and so favors legalization and regulation of physician-assisted death. A negative conception of liberty opposes govern-

mental interference in private decisions and so favors eliminating a blanket prohibition (see Stone, 1997: 128–129).

Disabilities faction

Before the Commission met it was assumed that there were only two positions on PAS—for or against. During the course of deliberations, however, a distinct third voice emerged. The MCDD's disability groups coalesced into a disabilities faction that supported a separate Procedural Safeguards Report. Their dissatisfaction stemmed from the belief that the disabilities viewpoint was being ignored. They strongly disagreed with the Model Statute Report's requirement that a physician be present at the time of death and they insisted that professional consultations be mandatory. They also objected to the premature and heavy-handed efforts to get a majority of the Commission on record in favor of physician-assisted death.

Depending upon the issue, the disabilities faction would side with either the personal autonomy or the sanctity-of-life faction. This complicated the debate, heightened conflict, and ultimately had the political effect of derailing a clear majority vote in favor of PAS.

Although members of the disabilities faction supported the right of individuals to make end-of-life decisions, they also argued that the disabled, segregated as second-class citizens, had special medical care and independent living needs that were not being met. As a result, vulnerable persons needed additional safeguards should some form of assistance in voluntary self-termination be legalized. They defined the problem of PAS as physicians, acting on outmoded and paternalistic social norms, dictating end-of-life decisions.

This core belief led the faction's leader and her supporters to object strenuously to the Model Statute Report requirement that a physician be present at the time of an assisted death.[19] Their arguments were clearly an effort to impose on other delegates an alternative problem definition.

Many members of the disabilities faction served on a committee to study safeguards for voluntary self-termination in the event it was legalized. The committee's report was discussed at MCDD meetings and became, with some changes, the Procedural Safeguards Report. It neither endorsed nor opposed assisted suicide, but instead emphasized the goal of reducing the need for assisted suicide by increasing society's support for the physical and emotional needs of disabled persons. Unlike the Model Statute Report, a physician's assistance in dying would be limited to advice, and the individual would carry out the final act resulting in death without a physician present. Under this report, a request for assistance in ending life would be based upon a subjective criterion of an ''individual's assertion of irreversible suffering from a physical condition at a level which the individual finds unbearable, despite offers of assistance or experience with alternatives and supports'' (MCDD, 1994: 2). The individual would have to undergo four consultations and the process certified by the probate court. The leader of the personal autonomy faction argued against the Safeguards Report's elimination of the presence of a licensed physician, a requirement thought to be needed to prevent abuses and to insure efficacy.

The disabilities perspective was given further visibility by the attendance of protestors from a small disability group.[20] At one meeting they rushed into the room, several in wheelchairs, carrying picket signs, chanting to the effect that the Commission should disband because none of its delegates was severely disabled, suffered from acquired immunodeficiency syndrome (AIDS) or had terminal illnesses.[21] Their fear plainly was that legalization of assisted suicide would lead to the slippery slope.

The members of the disability faction linked PAS to issues of particular concern to themselves. Their arguments also included positive and negative conceptions of liberty. Regarding the legalization and regulation of assistance in voluntary self-termination, their positive conception of liberty emphasized the various problems confronted by the disabled. Although many of these persons wanted additional end-of-life choices, it was more important for government to find ways of meeting their other needs so as to give them more choices in living. Their pessimistic view of human nature led to a negative conception of liberty because of expressed fears of vulnerability—society should not place lesser value on the lives of the disabled and should always respect their choices to live.

Sanctity-of-life faction

This faction, opposed to PAS under any circumstances,[22] was so small that its leader, nominated as the MCDD's secretary at the first meeting, failed to get a single vote.[23] As a small minority, its members worked to block the personal autonomy faction from achieving a clear voting majority for PAS. To this end it challenged the majority's problem definitions, proposed a new definition, emphasized problems with PAS, and offered alternative solutions.

Its articulate leader, knowledgeable in parliamentary procedure, was a thorn in the side of the personal autonomy faction, aggressively countering every one of their arguments. He articulated the MCDD's basic problem as the trend in society towards devaluing life, especially of the aged, chronically sick, disabled and poor. The solution was not PAS (a euphemism for "legalized killing") but rather action to prevent suicide by providing emotional, physical, social and spiritual support to those who were suffering.

When delegates talked about rational suicide, the leader of this faction denied its very existence, citing the large literature on suicide and depression. He posed the problem as the lack of knowledge of depression and its diagnosis by many health care professionals. When delegates talked about unbearable pain, he argued that new advances in pain management had the potential to eliminate almost all of it.

The members of this faction wanted to retain a ban on PAS, but the Commission spent little time talking about this option. At one regular meeting its leader led a discussion of a committee report that included all of the arguments traditionally invoked against PAS and other forms of aid-in-dying (MCDD, 1994: 19–20). This eventually became the "Report Opposing the Legalization of Assisted Suicide." At that meeting, an objection was raised to the report's phrase, "legalized killing," arguing that the words were designed to conjure up images of the gas chambers and Nazi doctors.

The leader of this faction worked continuously, with some success, to alter the Commission's agenda towards a greater focus on pain management, his favored solution to the problems of end-of-life suffering. At the February 3, 1994 meeting, he and his allies sought to derail discussion about the Model Statute Report by complaining that the Commission had not heard enough from pain management experts. They succeeded in passing a motion to hold a special meeting on the topic.[24]

The delegates of the sanctity-of-life faction argued that the alleged solution, PAS, was the problem. It amounted to legalized killing; PAS was unnecessary. If there was a problem, it was poor medical practice. Pain management and hospice care, if made widely available and properly implemented, were sufficient. PAS would create a host of problems and result in wholesale changes in medical practice. Its leader denied that the legalization of PAS would enhance liberty by creating additional end-of-life choices. PAS was "oxymoronic." It did not reflect an autonomous choice: "if one person agrees to help another person to kill

themselves you have a social act. You have a consensual self-killing of two people of another.''

Voting and the MCDD report

The Commission held five roll-call votes on substantive issues. Table II shows the results of these five votes as well as voting patterns for three of the votes that dealt specifically with assisted suicide. The first of these three votes was Concept Vote #2, a vote indicating support for the concept of legalizing assisted suicide. It secured a plurality of nine ''yes'' votes; however, this number was three votes short of the 12 needed to secure a majority. The second of the three votes was on the Model Statute Report. It received eight ''yes'' votes, four short of the 12 needed to secure a majority. The third of the three votes was on the Report Opposing Legalization of Assisted Suicide, which obtained only five ''yes'' votes; nine groups voted ''no.'' Thus, looking at these three votes, at least eight (and usually nine) of the groups on the Commission consistently supported legalizing assisted suicide. This number, however, was always short of the 12 needed for a majority because of the abstentions of at least seven groups and because of the opposition of the disabilities and sanctity-of-life factions.

The failure of a majority of groups on the Commission to support legalizing assisted suicide on Concept Vote #2 was a signal to members that the Commission would remain ''deadlocked'' on the key issue of PAS. As it was unable to agree on this key issue, the Commission had little alternative but to write a final report that included, along with a consensus report,[25] the separate views of each of the three factions. In the initial meetings of the Commission it seemed as if the personal autonomy faction, because of its numerical advantage, might secure a majority. The final report of the MCDD would advocate PAS, with a minority report by those few groups that were adamantly opposed. The emergence of a disabilities faction, and the spirited debate conducted by proponents and the leaders of each faction, however, ensured that there would be no compromise on this key issue. A report that offered three distinct problem definitions meant that the factions effectively canceled one another out in terms of political influence with the Michigan legislature.

Summary

The MCDD's deliberations provided an early glimpse of the arguments that are likely to be used in public settings on the issue of PAS. The Commission's delegates, as appointed representatives of various groups affected by the issue, were very concerned about how the problems were defined. They recognized that how problems are defined and how solutions are identified, presented and linked to those problems affect the content of public policy.

Commission delegates were from the start aware of the difficulty of reaching a consensus on PAS. In deliberations they drew on values that are commonplace in American politics in an effort to persuade others on the Commission to see problems and solutions in a different way. Although these efforts at persuasion did not change delegates' opinions very much, they did result in better understanding of opposing viewpoints. There was a general recognition of need for better pain management and more accessible hospice care even if factions disagreed sharply on whether these were sufficient as alternatives to PAS. The deliberations were an exercise in participatory democracy. Delegates interacted within a public setting where they had the opportunity to present and defend the positions of the groups they represented (and sometimes their own) and listen to and question the arguments of others. There was political maneuvering as delegates tried to change the

Table II. Patterns of voting on Michigan Commission on Death and Dying.

Five roll call votes on Commission (listed in the order they were taken)	
CON1[a] – Concept Vote #1 (decriminalize assisted suicide)	7-no, 7-abstain, 8-yes
CON2 – Concept Vote #2 (legalize assisted suicide)	6-no, 7-abstain, 9-yes
MSR – Model Statute Report	7-no, 4-abstain, 9-yes
OLAS – Report Opposing Legalization of Assisted Suicide	9-no, 6-abstain, 5-yes
PSR[a] – Procedural Safeguards Report	5-no, 6-abstain, 9-yes

[a]Since vote was not explicitly on the issue of legalizing assisted suicide, it was not used to develop scale.

Scalable voting patterns (Note: descending order reflects increasing support for aid in dying).

CON2	MSR	OLAS	GROUPS Coding of factions: no faction; sanctity-of-life faction; *disability faction*; **personal autonomy faction**.
No	No	Yes	*Head Injury*; Prosecutors; Right to Life; *Suicidologists*
No	No	Abstain	Hospice; Osteopaths
Abstain	Abstain	Abstain	Better Care; Hospitals; Non-Profit Homes; Physicians
Yes	Yes	No	**ACLU**; **Health Care**; **Hemlock**; **Nurses**; **Psychiatrists**; **Psychologists**; **Senior Advocates**; **Social Workers**; **State Bar**

Non-scalable voting pattern or groups absent and not voting

CON2	MSR	OLAS	GROUPS
Abstain	No	Yes	*Independent Living*
Abstain	Absent	Absent	AARP; *Retarded Citizens*

Source: Analysis of roll call votes as tabulated in MCDD (1994).

Commission's agenda, delay and speed its progress, alter the wording of specific reports, and organize and block the formation of majorities. The Commission, however, was not a legislature. Its delegates represented groups. They were not subject to the types of political party and executive branch pressures that exist within legislatures that promote the formation of majorities.

Ideas matter in politics. Persuasion can be a source of power, especially when opinion is evenly divided so that changing only a few votes can result in a different outcome. On the MCDD, the personal autonomy faction refused to compromise on the need for physician participation. The disabilities faction could not support that position and thus voted against the Model Statute Report. If there had been room for compromise on this issue, a few more votes might have been cast for the Model Statute Report, and it would have secured an absolute majority of 12 votes.

For the United States, the Michigan experience indicates that three different perspectives are likely to appear when PAS is debated publicly: the personal autonomy perspective at the liberal end of the pole, the sanctity-of-life perspective at the conservative end, and somewhere in the middle the disabilities perspective, which will include arguments consistent with but at other times at odds with the polar perspectives. These perspectives are likely to achieve greater or lesser significance depending upon the distinctive political culture of each state. For example, in Michigan the Catholic Church is sizable, resourceful and influential in state politics, especially on morality policy issues

such as PAS. About one-fifth of the state's population are registered Catholics. The same is not true in many other states.

Will these three different perspectives be found in the debate conducted in other countries? It seems likely that the distinctive political culture of a country will determine this. The people of the United States, in comparison to those in other post-industrial societies, display greater religiosity, with the consequence that morality policy issues have unusual force in politics. Thus, in countries where religiosity is lower, proponents of the ''sanctity of life'' may be less numerous and influential in the PAS debate. In the United States, the political culture is legalistic. There is a preference for the public resolution of conflict by the enactment of statute, through the initiative process, or by court decisions. In other countries, moral issues may be easier to keep out of the public domain. Thus, the tone of the PAS debate in other countries is likely to be less legalistic than in the United States, with the courts playing a less decisive role. There is likely to be greater respect for physician and patient autonomy and less scrutiny of medical care decisions at the end of life. The United States governmental structure is federal and highly fragmented. There are multiple points of access for interest groups. Venue shopping is common. Particularly at the state level, even small minorities, such as disabilities groups, will get a hearing for their point of view. In countries where governmental structure is unitary, it may be difficult for small minorities to get a hearing. Thus, with more interest groups participating, debate in the United States is likely to be noisier and more chaotic than in other countries, where the views of disabilities groups may not receive as much attention.

Postscript

The PAS debate, although now nearly 15 years old, still focuses upon problems, their definitions and their linkage to potential solutions. In the years since the MCDD met and issued its final report, the state did enact several laws in the areas of medical education, pain management, and related areas. So have other states. The failure of the MCDD to reach agreement on PAS probably encouraged the efforts of opponents of PAS in the legislature to work even harder to enact a permanent ban. Those efforts were finally rewarded in 1998. In the same year, the conviction and imprisonment of Kevorkian on a charge of second-degree murder in the case of Thomas Houk finally pushed PAS off the governmental and public agendas in Michigan.

Oregon now has a number of years of experience with PAS. To date, only small numbers of terminally ill patients each year in that state have used PAS. Thus, several arguments used by opponents on the MCDD against aid-in-dying would seem to be less credible, such as ''some people will feel an obligation to die,'' that ''it will result in a slippery slope,'' and ''it will be difficult or impossible to restrict the categories of people who will be eligible to seek aid in dying.'' Nevertheless, plenty of arguments, both for and against PAS, remain credible. These arguments will be grounded in deeply held values upon which compromise is difficult or impossible. Renewed conflict is certain should right-to-die advocacy groups try again to use the initiative process to repeat the Oregon success in other states.

The future importance of the PAS issue internationally is likely to hinge on the perceived need for it. Advances in palliative care and hospice, the establishment of clearer guidelines for physicians in the use of drugs that may inadvertently hasten death (the double effect), and increased use of alternatives such as terminal dehydration may reduce the perceived need for PAS.

Acknowledgments

This research was supported in part by a grant from the Barber Fund, Center for Legal Studies, Wayne State University, USA.

Endnotes

1 Vacco v. Quill, 117 S. Ct. 2293, 138 L. Ed. 2d (1997) Washington v. Glucksberg, 117 S. Ct. 2258, 138 L. Ed. 2d 772 (1997).
2 Morality issues recently considered by governmental policy makers, in addition to PAS and euthanasia, include abortion, animal rights, capital punishment, divorce, drunk driving, gambling, homosexuality, gun control, pornography, public school prayer, sex education in public schools, and others; see Mooney (2001).
3 Act 3, Public Acts of 1993 (1993 PA 3).
4 Groups representing health care institutions and professions: Michigan Association of Osteopathic Physicians and Surgeons, Michigan Association of Suicidology, Michigan Hospital Association, Michigan Nurses Association, Michigan State Medical Society, Michigan Psychiatric Society, Michigan Psychological Association. Groups connected with long-term care: Citizens for Better Care, Health Care Association of Michigan, Michigan Hospice Organization, Michigan Nonprofit Homes Association. Professional groups outside health care: National Association of Social Workers—Michigan Division, Prosecuting Attorneys Association of Michigan, State Bar of Michigan. Groups representing the mentally and physically disabled: Michigan Association for Retarded Citizens; Michigan Council on Independent Living; Michigan Head Injury Survivor's Council. Senior groups: American Association of Retired Persons (AARP), Michigan Senior Advocates Council. Other civic groups: American Civil Liberties Union (ACLU), Hemlock of Michigan, Right to Life of Michigan. Summary identifiers are used in subsequent notes.
5 Health Care, Nurses, Senior Advocates, Social Workers, Psychologists, ACLU, Hemlock, Psychiatrists, State Bar.
6 Suicidology, Independent Living, Head Injury Survivors, Retarded Citizens.
7 Hospice, Right to Life, Prosecuting Attorneys.
8 Hospital, Non-Profit Homes, Medical Society, Better Care.
9 AARP, Osteopathic.
10 For example, prescribing lethal drugs and giving instructions on how to use them to bring about death.
11 This is labeled voluntary active euthanasia, and is murder, as indicated by the conviction of Kevorkian for a televised act of euthanasia.
12 Notes from: Commission meeting September 1, 1993; public hearing in Detroit, October 8, 1993; Commission meetings December 20, 1993; February 3, 1994; March 30, 1994; April 12, 1994.
13 Notes from public hearing in Wayne County, November 8, 1993.
14 Notes from Commission meeting, December 20, 1993.
15 Notes from Commission meeting, March 30, 1994.
16 Notes from Commission meeting, February 3, 1994.
17 Notes from Commission meeting, February 3, 1994.
18 This term as used in the Model Statute Report referred to physician-assisted death; however, its general use often refers to a broad range of care given to the terminally ill, such as hospice care.

19 Notes from Commission meeting, February 3, 1994.
20 Americans Disabled for Attendant Programs Today (ADAPT).
21 Notes form meeting held March 4, 1994. See *Detroit News and Free Press*, March 5, 1994, A:3,6.
22 The members of this faction, serving on a public body, did not openly express a religious point of view, presumably respecting the separation of church and state. The leader of the faction was a Catholic and another member was a Catholic priest. Archbishop (now Cardinal) Adam Maida was the first to speak before the Commission at a regular meeting and gave an eloquent presentation of the Catholic perspective.
23 Notes from Commission meeting of July 30, 1993. Another nominee for this office, who was also a right-to-life supporter, received three votes.
24 At the Commission meeting of February 3, 1994, the leader of the sanctity-of-life faction argued for the need for additional testimony on pain management. A motion to hold a special meeting was passed 11 to 7. The expert testimony was presented on March 4, 1994, before, and in conjunction with, a regularly scheduled meeting of the Commission.
25 The Consensus Report included recommendations for public education about advanced directives, patient control over medical decisions, and the right to treatment for pain. It recommended legislative action to increase suicide prevention measures, the referral of individuals asking about self-termination to supportive services, improved access to palliative care and hospice services, and modifications of the use of triplicate prescriptions (MCDD, 1994).

References

Annas, G. J. (1993). Physician-assisted suicide—Michigan's temporary solution. *New England Journal of Medicine*, *328*, 1573–1576.

Brody, H. (1993). Legislative ban on assisted suicide: Impact on Michigan's medical practice. *Michigan Medicine*, *92*, 32–34.

Clark, N. (1997). *The politics of physician-assisted suicide*. New York: Garland.

Dillon, M. (1993). Argumentative complexity of abortion discourse. *Public Opinion Quarterly*, *57*, 305–314.

Fairbanks, J. D. (1977). Religious forces and 'morality' politics in the American States. *Western Political Quarterly*, *30*, 411–417.

Fino, S P., Strate, J. M., & Zalman, M. (1997). Paging Dr. Death: The political theater of assisted suicide in Michigan. *Politics and the Life Sciences*, *16*, 87–103.

Glick, H. R. (1992). *The right to die: Policy innovation and its consequences*. New York: Columbia University Press.

Glick, H. R., & Hutchinson, A. (2001). Physician-assisted suicide: Agenda setting and the elements of morality policy. In C. Z. Mooney (Ed.), *The public clash of private values: The politics of morality policy* (pp. 55–72). New York: Chatham House.

Haider-Markel, D. P., & Meier, K. J. (1996). The politics of gay and lesbian rights: Expanding the scope of the conflict. *Journal of Politics*, *58*, 332–350.

Hoefler, J. M. (1997). *Managing death*. Boulder, CO: Westview Press.

Hoefler, J. M., & Kamoie, B. E. (1994). *Deathright: Culture, medicine, politics, and the right to die*. Boulder, CO: Westview Press.

Jones, B. (1994). *Reconceiving decision-making in democratic politics*. Chicago: The University of Chicago Press.

Michigan Commission on Death and Dying (1994). *Final report*. Lansing, MI: The Commission.

Mooney, C. Z. (2001). The public clash of private values: The politics of morality policy. In C. Z. Mooney (Ed.), *The public clash of private values: The politics of morality policy* (pp. 3–18). New York: Chatham House.

Mooney, C. Z., & Lee, M.-H. (1995). Legislating morality in the American States: The case of pre-*Roe* abortion regulation reform. *American Journal of Political Science*, *39*, 599–627.

Mooney, C. Z., & Lee, M.-H. (2000). The influence of values on consensus and contentious morality policy: U.S. death penalty reform, 1956–82. *The Journal of Politics*, *62*, 223–239.

New York State Task Force on Life and the Law (1994). *When death is sought: Assisted suicide and euthanasia in the medical context*. Albany, NY: New York State Task Force.

Persels, J. (1993). Forcing the issue of physician-assisted suicide: Impact of the Kevorkian case on the euthanasia debate. *Journal of Legal Medicine*, *14*, 93–124.

Rochefort, D. A., & Cobb, R. W. (1994). *The politics of problem definition. Shaping the policy agenda*. Lawrence, Kansas: University Press of Kansas.

Stone, D. (1997). *Policy paradox: The art of political decision making*. New York: W.W. Norton & Company.

Zalman, M., Strate, J., Hunter, D., & Sellars, J. (1997). The Michigan assisted suicide three ring circus: The intersection of the common law and politics. *Ohio Northern University Law Review*, *23*, 863–968.

Biographical Notes

John M. Strate is Associate Professor of Political Science at Wayne State University where he also directs the Master of Public Administration program. His current research interests include physician-assisted suicide and pain management. Marvin Zalman is Professor in the Criminal Justice Department at Wayne State University. He has published in the areas of judicial sentencing and assisted suicide policy. Denis Hunter earned an MS degree in Criminal Justice at Wayne State University.