



PHYSICIAN-ASSISTED SUICIDE

Political, Pastoral Challenges Ahead

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Physician-assisted suicide is an issue with national scope and emerging intensity in the United States. In Catholic circles, it tends to fall within the broader ambit of pro-life issues but does not receive the same weight, role and attention as abortion. In the wider civil society, it is not necessarily linked to abortion or stem-cell research. Instead, physician-assisted suicide is treated on its own terms, and, as such, poses a long-term challenge for Catholic health care and the Catholic Church. Rather than simply being clustered with other pro-life issues, physician-assisted suicide demands attention, resources and a strategic vision of its own.

The narrative around physician-assisted suicide stretches across decades and prolonged debate, encompassing such milestones as Jack Kevorkian, MD's espousal of terminally ill individuals' right to receive medical assistance to end their lives, the 1997 U.S. Supreme Court decision that there is no constitutional right to physician-assisted suicide — thereby leaving the matter up to state legislatures — and campaigns in Oregon, Washington and Vermont that led to "Death with Dignity" laws in those states.

We can expect debate over the issue to continue, broaden and intensify, thanks to three factors: First, there are nationally based, well-funded organizations like Compassion & Choices (www.compassionandchoices.org) and the Death with Dignity National Center (www.deathwithdignity.org), "one-issue" organizations committed to advocate, lobby for and publicize the issue of physician-assisted suicide.

Second, medical technology — a distinguishing product of American science and industry — will continually present new and different

questions for patients, their families and medical professionals.

Third, there are basic cultural characteristics of American society that predispose some sectors of opinion toward the idea of physician-assisted suicide. These include a strong strain of individualism, a belief in freedom of choice and a determination to control the environment of one's existence even to the timing of death. Physician-assisted suicide arguments often are pitched to these three cultural values.

For Catholicism, physician-assisted suicide presents multiple challenges. Some of the issue's central tenets directly challenge Catholic teaching about the sacredness of life, the dignity of the person and the moral meaning of stewardship of life. Catholicism also represents a public position in which religious moral ideas are tightly tied to and represented by a range of social institutions. The institutions embody the ideas and are guided by them. When the ideas are challenged, so are the institutions. The broad fabric of Catholic health care, from acute care hospitals to long-term care



facilities, is recognized throughout the country as a prominent part of the physician-assisted suicide debate.

The complex character of physician-assisted suicide not only will test the Catholic Church's moral ideas and social institutions, it also will place demands on the quality of pastoral care in parishes, hospitals and nursing facilities.

THE MASSACHUSETTS STORY

It may be helpful to examine the Massachusetts "Death with Dignity" ballot initiative as a case study. For years, physician-assisted suicide bills had been filed in the state legislature without success. The summer of 2011 brought a change in tactics: A citizens' committee advanced a ballot initiative. To successfully put a proposed law on the ballot in Massachusetts, such a committee has to collect thousands of signatures at two different moments in the process. The question at issue can be reviewed and taken up by the legislature (Death with Dignity was not), and, finally, the Attorney General must authorize putting it on the ballot.

The physician-assisted suicide advocates secured a place for their proposed law on the November 2012 ballot as Question 2, which detailed the proposed law and explained to voters, "A yes vote would enact the proposed law allowing a physician licensed in Massachusetts to prescribe medication, at the request of a terminally ill patient meeting certain conditions, to end that person's life."

The proposed law was defeated by 2 percentage points.

In its voting patterns, Massachusetts classically is a "blue," or Democratic Party, state and heavily in favor of abortion rights. It is a state where 50 percent of the voters describe themselves as more secular than religious in their worldview. All these characteristics made Massachusetts a prime candidate for passing a physician-assisted suicide law. Paradoxically, it also is a state in which 40 percent of the citizenry is Catholic.

When supporters undertook a ballot initiative, opponents of physician-assisted suicide had to build a strategy from scratch. The Massachusetts Catholic Conference decided at the 2011 fall meeting of the bishops to use the combined resources of the state's four Catholic dioceses and the con-

ference staff. This basic decision then led to others: First, because of the very scope and complexity of the challenge posed by physician-assisted suicide in a blue, pro-abortion rights state, the consensus was to engage the public relations and public affairs firm Rasky Baerlein Strategic Communications, along with the Democratic strategic planning and opinion research firm Marttila Strategies. Together, the two Boston-based firms had never lost a Massachusetts ballot initiative, with 12 victories to their credit.

Second, it was quickly decided that the Catholic Church by itself could not defeat the physician-assisted suicide challenge. Given the makeup of

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the electorate and the complexity of the issue (about which the citizenry held strong views already), it would be essential for the church to be deeply involved — but it could neither lead the public campaign nor be the face of it.

Third, from the outset, the strategy for the church was designed with an internal and an external component. Internally, the Catholic effort would be directed in its parishes throughout the state's four dioceses in order to solidify support within the community of Catholics. The internal work involving parishes, Catholic TV and colleges was the essential starting point for the successful campaign. Cardinal Sean O'Malley, who led the effort in Boston, used parish video messaging to address Catholics. Throughout the state, panels of experts staffed public meetings and conferences and parishes received extensive documentation for distribution.

Externally, the strategy looked quite different, for the audience went beyond Catholics to encompass all Massachusetts voters. Opposition to physician-assisted suicide was consciously ecumenical, interfaith and secular (the medical community); the Catholic Church was engaged,



but as part of a broader effort. The arguments used were less normative than those of the internal strategy.

The crucial component of the external strategy was Marttila's polling, carried out statewide on four occasions between January 2012 and October 2012. The polling results shaped the strategy and tactics of the campaign; more than 3,000 citizens were interviewed, and several focus groups complemented the interviews.

The polling showed that opponents of physician-assisted suicide faced a significant, basic political and cultural challenge. Massachusetts citizens answered yes, by a 2-1 margin, to the question, "Do you think that terminally ill patients should have access to physician-assisted suicide?" This meant enormous difficulties for a campaign using solely moral arguments against physician-assisted suicide.

Hence, the strategy shifted to the tactical. The polling indicated voters were uncomfortable with several dimensions of the proposed ballot initiative: (1) no psychiatric evaluation was required (consultation with physicians was); (2) doctors were expected to predict death within six months; (3) no family members needed to be involved in the decision; (4) the prescribed drug was available at a local pharmacy; (5) administering the drug (by the patient) involved scores of pills. Therefore the external strategy basically focused on these aspects of the ballot initiative, along with some others.

There is a mine of detailed empirical data about demographics, basic convictions of citizens and shifting opinions as the campaign progressed. In the crucial days from Labor Day to Election Day, public opinion shifted; in spite of a basic conviction that physician-assisted suicide should be available, significant segments of the electorate found the specific details of the ballot initiative so defective that they opposed it.

In short, January 2012 polling showed physician-assisted suicide was favored by 20 points. On Election Day, Nov. 6, 2012, physician-assisted suicide was defeated by 2 points.

It should be noted that the victorious strategy was very tailored to Massachusetts, its politics, culture and electorate. It also was clear that the internal strategy, sharpening the understanding Catholics had of the church's teaching on end-of-life care, was essential to the victory.

Those of us who lived through the Massachusetts experience are convinced that a national challenge in multiple states lies ahead. Drivers of this challenge are nationally organized advocates of physician-assisted suicide, a dynamic medical technology and a broad receptivity to some of the physician-assisted suicide arguments such as autonomy, control and maximizing personal choices.

TEACHING, STRATEGY, MONEY

There is no claim here that the Massachusetts strategy can be transferred directly into other states, but that is not a prediction of victory for physician-assisted suicide. It can be defeated, but only with planning and strategy. The strategy must include intellectual, organizational, financial and pastoral components.

Physician-assisted suicide advocates wish to shape the argument in terms of choice, freedom and self-determination. Catholic teaching on end-of-life issues, while firmly opposed to physician-assisted suicide, has the resources to enter the public debate effectively.

The basic principles of care of the terminally ill in Catholic moral teaching provide scope for a range of choices, rooted in the burden-benefit calculus of treatment, which provide a framework for patients and families to resist treatments offering no benefit, while at the same time drawing a moral line against physician-assisted suicide. The resources of Catholic teaching are equal to the physician-assisted suicide debate, but the understanding of them, even among Catholics, is quite minimal. Within the Catholic community there is a work of sharing the tradition that needs to be addressed early and often.

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The physician-assisted suicide challenge, however, is not a purely intellectual one. Whether the question is before a legislature or the electorate as a whole, strategic organization is at the heart of a successful effort. The techniques and tools

of a modern political campaign are essential to success. The fact that physician-assisted suicide involves deeply spiritual and moral values does not negate the fact that strategy, tactics and alliances are needed to defend those values. An understanding of the particular culture of a state, the core values its citizens hold, and which religious and secular allies are available, are all prerequisites for success.

Strategic decisions based on empirical data about which ideas should lead a campaign and how to position the church in a broader network are essential questions to resolve at the outset. But good ideas and good strategy are still not enough. Especially for a ballot initiative, money is essential. The principal cost is the use of television and other media. In the dynamic atmosphere of a campaign for the public mind, there is no substitute for the ability to use television ads in a systematic fashion.

Precisely because the advocates of physician-assisted suicide think of their work on a national scale and have the means to support local efforts with national resources, the opponents of physician-assisted suicide must have a realistic sense of what they face and a plan to raise money over several months. The Catholic experience from the states of Washington to Massachusetts illustrates that adequate funding runs in the millions. Coalitions need to be built because the church cannot and should not be the primary source of funding in most cases.

PALLIATIVE CARE A TOOL

At the heart of the physician-assisted suicide debate is the moral-medical distinction between curing and caring for patients. The U.S. health care system has more options for curing illness than any other in the world. But even here, there comes a moment when caring is the imperative because curing is no longer possible. At this point, the Catholic pastoral tradition becomes a great asset.

Guided by moral principles of “do not kill” and the complementary criteria of measuring appropriate care by the burden-benefit distinction, Catholic institutions can provide a mix of spiritual, moral and medical resources for patients and families. This tradition of caring has relevance for the external strategy, because across the substantial divide in the debate between advocates and opponents of physician-assisted suicide, there is broad agreement on the value of palliative care.

Catholic facilities across the country are schooled in this tradition of palliative care. Wherever possible, shifting the end-of-life debate in this direction should be a high priority for opponents of physician-assisted suicide.

The four dimensions of an external/internal strategy to oppose physician-assisted suicide — intellectual, organizational, financial and pastoral — cannot be mobilized on an ad hoc basis. The premise of this article is that the church and the wider civil society are confronted with an ongoing national challenge. The four strategy components require systematic preparation and engagement. At the national level, the resources of the United States Conference of Catholic Bishops and Catholic Health Association are at the heart of the national effort; translating these resources to efforts at the state level will be crucial.

The state level is presently the primary political arena for the physician-assisted suicide debate. Some version of physician-assisted suicide is being proposed in at least seven states. These bills have very different possibilities of passage, but the physician-assisted suicide movement holds long-term goals and a persistent, incremental style of operation. To compete with it, physician-assisted suicide opponents need similar characteristics but a different vision of end-of-life care.

The distinction between a ballot initiative or referendum and a legislative measure is crucial. The former is a more complex, more expensive challenge, appealing to the electorate as a whole. It is these efforts that particularly need professional engagement beyond the usual resources of the church.

In the end, the sharing of resources through dioceses and Catholic health care institutions was a powerful support to the Massachusetts campaign. In response to an appeal from Cardinal O'Malley, financial help from dioceses, CHA and other Catholic systems was very welcome.

One case study will not be sufficient to determine how physician-assisted suicide opponents should think, act and share. But recognizing the scope of the challenge physician-assisted suicide poses, and preparing systematically for it, are the principal lessons to be absorbed.

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