

AN ABSTRACT OF THE THESIS OF

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The purpose of this study is to investigate the role of narratives within public policy, surrounding the issue of doctor-assisted suicide. Specifically, this study attempts to examine the way(s) in which narratives both shape and influence public policy; pertaining to Measure 16, Oregon's Death with Dignity Act. Narrative communication involving the issues of Measure 16 and doctor-assisted suicide exist in a variety of facets. These include letters sent to reader response forums in newspapers and magazines, the Oregon Voters Pamphlet, and letters sent directly to government officials and offices at the State Capitol. By examining the role of narrative within the doctor-assisted suicide debate, this study will demonstrate how the discourse operates (either intentionally or unintentionally) from a rhetorical standpoint, which influences the way voters cast ballots at the voting booth. A contemporary approach to narrative, as illustrated by Sonja K. Foss, will be applied in this study as a method for investigating narratives pertaining to Measure 16 and the controversy of doctor-assisted suicide. Foss' approach works effectively in explaining the use of narratives as a means of influencing within the public policy arena. This study attempts to show how language is constructed in order to shape and promote views towards ballot measures and human rights issues. Additionally, this study intends to increase the understanding of narrative's function within discourse heavily relied upon by voters and lawmakers during election time.

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Oregon's Death with Dignity Act: A Rhetorical Criticism of
Narrative Within Public Policy

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TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION.....	1
Literature Review.....	5
Artifacts For The Study.....	5
Literature Review on Narrative.....	6
Statement of Method.....	20
Works Cited.....	22
CONTEXTUAL GROUND: THE HISTORY AND EVOLUTION OF DOCTOR-ASSISTED SUICIDE.....	24
A CRITICAL EXAMINATION OF RHETORICAL NARRATIVE FUNCTION IN MEASURE 16--DEATH WITH DIGNITY-- RELATED DISCOURSE.....	47
Narrative One.....	50
Narrative Two.....	54
Narrative Three.....	59
Narrative Four.....	64
Narrative Five.....	68
Narrative Six.....	72
Narrative Seven.....	76
Narrative Eight.....	81
Works Cited.....	86
NARRATIVE DISCOURSE AND MEASURE 16--OREGON'S DEATH WITH DIGNITY ACT.....	87
Interpretation of Primary Sources.....	87
Interpretation of Secondary Sources.....	90
Conclusions.....	92

TABLE OF CONTENTS (Continued)

	<u>Page</u>
Implications for Future Study.....	94
Works Cited.....	95
BIBLIOGRAPHY.....	97
APPENDIX.....	101

Oregon's Death with Dignity Act: A Rhetorical Criticism of Narrative Within Public Policy

Chapter One:

Introduction

Countless forms of narratives and definitions of the communicative act exist throughout the world. While narrative is both universal and infinitely defined, there are usually several mediums associated with it. These usually include an ordered mixture of oral and written language, pictures, and gestures. Although the word narrative is often ambiguous, there are many widely accepted definitions of the term. Gerald Prince states, "Narrative is the representation of real or fictive events and situations in a timed sequence"(1). Narrative has been referred to as the succession of events--real or fictitious--that are the subjects of discourse, and to their several relations of linking, opposition, and repetition (Genette, 25). Additionally, narrative has been referred to as not the event that has been recounted, but the event that consists of someone recounting something--the act of narrating itself.

Throughout the decades ordinary citizens have relied on the narrative communication form as a means of ordering and presenting their views concerning ballot measures and current laws. While the use of narrative allows a voter to present his or her "world view" to others, it simultaneously attempts to change or enhance another voter's perception of an issue or measure. Furthermore, narratives have the potential to facilitate or discourage a particular election outcome. One such occurrence in which the power of narrative appears to have played a role in an election outcome is in the 1994 Oregon election involving Measure 16, known as the Death with Dignity Act.

One of the most profound and troublesome issues facing humanity was put into the hands of Oregon voters in 1994. During this state-wide election the issue of approving

legalizing doctor-assisted suicide was at the center of controversy. The Death with Dignity Act would allow any person over age 18, who has been determined to have less than six months to live, to receive a prescribed lethal dose of medication. While heated debates transpired among persons and groups such as The National Hemlock Society, Catholic churches, and Barbara Coombs Lee, a chief petitioner for the Measure, the initiative narrowly passed with a 51 to 49 percent margin (Carr, 52). Oregonians had made a strong statement concerning an individual's rights and the issue of life and death. Yet, preceding this monumental law in Oregon were years of unsuccessful attempts at legalizing doctor-assisted suicide in the United States.

Although doctor-assisted suicide had been practiced in the other countries such as Australia and the Netherlands, Oregon became the first state in America to pass such a law in 1994. The first time the question of euthanasia was put to voters in the United States occurred in the state of Washington in 1991. At this time voters rejected the initiative with 46 percent in favor of the law and 54 percent opposed. One year later an initiative in California involved doctor-assisted suicide. Again, the initiative was defeated with 46 percent of voters in favor of the Measure and 54 percent opposed (Garrow, 59). In comparing Oregon's election outcome involving the assisted suicide issue to those elections where the euthanasia issue was defeated, the question arises, "What had made the difference in Oregon?" Were Oregonians simply more open and objective to allowing the freedom of doctor-assisted suicide to be an option for terminally ill persons? Did something exist which can be identified as specifically helping to propel and promote the issue of doctor-assisted suicide to the forefront of the minds of Oregon voters?

The purpose of this study is to investigate the role of narratives within public policy, surrounding the issue of doctor-assisted suicide. Specifically, this study attempts to examine the way(s) in which narratives both shape and influence public policy; pertaining to Measure 16, Oregon's Death with Dignity Act. Narrative communication involving the issues of Measure 16 and doctor-assisted suicide exist in a variety of facets.

This includes letters sent to reader response forums in newspapers and magazines, the Oregon Voters Pamphlet, and letters sent directly to government officials and offices at the State Capitol. These narratives provide a lens through which one can view a person's attitude, opinions, and beliefs towards not only doctor-assisted suicide, but life in general. By examining the role of narrative within the doctor-assisted suicide debate, this study will demonstrate how the discourse operates (either intentionally or unintentionally) from a rhetorical standpoint, which influences the way voters cast ballots at the voting booth.

In conducting this study it is important to realize that there are limitations which must be taken into account. First, the discourse being examined occurs within a particular context. Specifically, this context involves the controversy surrounding doctor-assisted suicide. Therefore, the narratives chosen for this study are those which refer to the issues found within this context. Another limitation of this study deals with the time frame within which the narratives are selected for examination. This time frame refers to the period in which voters discussed and conveyed feelings and beliefs towards doctor-assisted suicide and Measure 16. This limitation is somewhat uncontrollable, as it is determined by those who write the narratives and discuss the issues. The final limitation of this study concerns what actually constitutes a narrative to serve as part of the artifact. The definition of a narrative--in terms of its use within this study--will be outlined in this chapter. This limitation is purposely created as a means of defining discourse which constitutes a narrative.

While television and radio advertisements contain arguments which are influential to voters during election time, this study focuses on Measure 16 related written discourse which attempted to persuade voters in Oregon. The research for this narrative analysis began with a compilation of 30 narratives. After reviewing the content of each narrative, I chose the eight narratives existing within this study. The following criteria were utilized in order to narrow down the original number of narratives. First, I chose the number of narratives that I felt I could handle within the space permitted in this narrative criticism.

Next, I chose a number that would allow for a variance of narrator's opinions and beliefs concerning the issues of Measure 16 and doctor-assisted suicide. Finally, I chose narratives that represented a variety of sources. These sources include the 1994 Oregon Voter's Pamphlet, the *Oregonian* newspaper, and from the files of offices within the Oregon State Capitol. All quotes from within the analysis of each narrative come from the actual document created by various citizens of Oregon. These narratives, in full, reside within the appendix of this thesis. The narratives are documented from A-H. They are listed in the appendix in the same order as they appear within the study. Finally, the narratives which represent the secondary category of sources within this study were written by citizens after the passage of Measure 16. Yet, the discourse pertains to the measure and the issue of assisted suicide.

This study hopes to make contributions of both social and academic significance. By critically analyzing narratives relating to public policy, this body of research takes on rhetorical significance in terms of how language is constructed in order to shape and promote views towards ballot measures and human rights issues. Additionally, this study intends to increase the understanding of narrative's function within discourse heavily relied upon by voters and lawmakers during election time. Therefore, the function of each narrative will be analyzed to determine its potential to shape and influence public policy. Furthermore, each narrative will be evaluated in terms of how it helps increase our understanding of this communicative act within a defined setting involving a controversial issue. Hopefully, this study will allow for the expansion of narrative's influence, in the way that narrative will be shown as a tool voters use to both promote and oppose potential laws. By recognizing the importance of human communication among voters via narratives, this study will hopefully bring about future analysis in the area of public policy--involving the role of narrative. Finally, this study will help magnify the importance of how one person's views and experiences can effect another person's way of thinking on issues and situations.

Literature Review

The first part of the literature review will include an overview of the narratives which make up the artifacts analyzed within this study. The second part of the review will investigate theoretical and critical literature on narrative. Finally, a statement of method for analyzing the narratives as a form of persuasive rhetoric will follow the literature review.

Artifacts For The Study

The narratives selected for study are divided into two categories: primary and secondary sources. Together, this collection of narratives creates the artifact within this rhetorical study. The primary sources are composed of discourse from the Oregon Voters Pamphlet. The discourse from the Oregon Voters Pamphlet are arguments written by residents of the state of Oregon who either favor or oppose Measure 16. Each piece of discourse represents testimony by the narrator. Additionally, the person's position on Measure 16 and doctor-assisted suicide is stated and explained. Although each of these primary sources will be examined individually, their results will be analyzed collectively, in an attempt to draw conclusions from the entire category of narratives.

The secondary sources within this study embody letters sent specifically to Representative Jo Ann Bowman at the Oregon State Capitol and to elected officials, on the whole, from around the state of Oregon. Representative Bowman gave me access to her file on Measure 16 while I worked as an intern at the State Capitol. This file included personal narratives concerning Measure 16 written by citizens of Oregon. Each of these letters include the narrator's thoughts, opinions, and position towards the measure and doctor-assisted suicide. I decided to include this category of sources within my study because of the rare opportunity I was given to obtain the discourse, my personal interest in the discourse after I initially reviewed each letter, and because of the unique opportunity I

had to analyze rhetoric which citizens had originally created for the sole purpose of one audience--members of the Oregon Legislature.

As with the primary sources, these items of discourse within the secondary source category will be examined individually. Furthermore, the data collected from the examination of these narratives will be analyzed as a whole. This will be done as a means of drawing conclusions from the entire category of similar narratives.

Literature Review on Narrative

In his book, Narrative as Communication, Didier Coste (1989) discusses narratology or the study of all acts of communication that carry narrative meaning and significance (3). Coste believes that narrative(s) can not exist independently from an act of communication and that "an act of communication is narrative whenever and only when a transitive view of the world is the effect of the message produced" (4). Coste views verbal narrative communication as something which presents itself as a ready-made object of verbal study, to be known, and which gives the illusion of knowing itself. This, in turn, saves us (the recipient of the narrative) from having to determine what the narrative is "actually" saying. Coste uses an equation to represent the formation of a narrative. This equation includes the following: Narrative=Reality=History.

In his discussion of the roles which exist within a narrative, Coste paraphrases Tesniere in concluding that "actant" are the different operators that participate in the narrative process. Within the arena of "actant" is the narrator who has the task of fulfilling the narrative function. Included in this function is the narrator's job of controlling the structure of the text. He has a mission, perhaps nothing more than a function to tell. Coste believes that there is no such thing as a nonnarrated story and that a narrator is the subject of enunciation--consisting of one or more utterances to form the narrative.

Coste's writing on narrative as communication will contribute to my rhetorical study of narratives pertaining to Measure 16. His statements about narratives carrying significance and meaning will be shown in the narratives I examine within my study. The narratives analyzed were most likely written to make an impact on those who read them. Additionally, these narratives may have contributed to others taking action upon their (the narratives) arrival at state departments and newspapers. This, in turn, shows the significance of the narratives. Coste's beliefs concerning the function of a narrator may play a role in what I determine the narrator of narratives must be doing or have done--in order for it to be included as an artifact for the study. The functions of narrative discourse are further examined in the 1985 work of Lucaites and Condit.

In their essay, "Re-constructing Narrative Theory: A Functional Perspective," Lucaites and Condit discuss *narratio* in terms of how it emphasizes the numerous functions of narrative discourse. The writers contend that one should be concerned with the interplay that exists between the form and function of all types of discourse genres. Lucaites and Condit examine the three goals which all discourse attempts to achieve. These goals include: to delight, to instruct, and to move. Additionally, the writers discuss the three primary modes of discourse which include, poetic, dialectic, and rhetoric (92).

Lucaites and Condit state, "Narratives represent a universal medium of human consciousness" and that "Metacodes allow for the transcultural transmission of messages about a shared reality" (90). Within rhetorical narratives, the author, narrator, and speaker are all treated as one. To separate each of these would create an unmanageable situation for the audience. Furthermore, interaction occurs between the speaker's credibility and the narrative itself. Both strengths and weaknesses of the speaker are often found in the narrative (102).

Lucaites and Condit contend that discourse exists in a variety of relationships with the real world. The function of each form of discourse interacts with the elements of a narrative (plot, character, narrative voice, and so forth) to produce varying characteristics.

Specifically, rhetorical narratives must display “brevity, avoid contradictions, demonstrate unities of directions and purpose, and integrate the credibility of narrators, authors, and speakers” (104).

Lucaites and Condit conclude that narrative must be explored in all functional contexts, as narrative participates in a vast range of communication settings. Additionally, special attention should be given to both political and social implications of the use of narratives in various contexts. If these implications are ignored, one is failing to recognize the search of a universal narrative “metacode” (105). Lucaites and Condit discuss narrative and the terms which relate to the communicative act. Additionally, Gerard Genette furthers the discussion of narrative and its components within his own work.

In Narrative Discourse: An Essay In Method, Gerard Genette discusses three distinct notions under the term narrative. Each of these notions represent separate meanings for what makes up a narrative. The first notion refers to the narrative statement, where the oral and/or written discourse undertakes to tell of an event or series of events. The second notion refers to the succession of events, real or fictitious, that are the subject of discourse. The final notion concerns the oldest meaning of narrative, which refers not to the event recounted, but the event that consists of someone recounting something. This can be viewed simply as the act of narrating taken in itself.

Genette analyzes narrative discourse as the study of the relationships between narrative and story--or narrative and narrating. He believes that narrative is a doubly temporal sequence. There exists the time of the thing being told and time of the narrative itself. Genette states, “The function of a narrative is simply to tell a story and therefore to ‘report’ facts--real or fictive.” (161). Narrative information has degrees, with the narrative furnishing the reader with more or few details, in more or less a direct way, and keeping the reader at a greater or lesser distance from what the narrative tells. The participant within a narrative takes on a perspective, thus acquiring a “vision” or “point of view”.

Genette writes that it is virtually impossible to not be able to locate the story in regards to how the narrating act itself is presented. The narrative is either told in past, present, or future tense. Although the narrating place is rarely specified, it is almost never relevant to what is said.

The views and opinion Genette discusses in relation to narrative discourse ties into my study of narratives relating to Measure 16. The meanings of narratives offered by Genette does encompass the narratives I have selected as artifacts to study. Furthermore, I am in agreement with Genette's definition of a narrative's function, although it is a bit broad and overly accepting of discourse which may not be "typically" viewed as narrative communication. While Genette views narrative discourse as a form of storytelling, Livia Polanyi expands on this notion by specifically discussing narrative and the American story.

In her book, Telling The American Story, Livia Polanyi's states that there are various forms of narratives which can be viewed as describing the world and state of affairs within it. One form of narrative is the story. Polanyi argues that it is far from a simple task to determine what a story is "about" in every instance. She states, "Many stories are made up of "thisses" and "thats", however there are numerous events and states of affairs involving numerous characters and situations" (2).

Polanyi considers the role of a narrator in stories. She discusses the narrator as being viewed more in the role of a teller within the story. The tellers are aware of the need to separate the more important information from the entire "group" of available information to share when telling a story. According to Polanyi, "A teller describes events which took place in a specific past time in order to make some point about the world which the teller and the story recipients share" (16). In storytelling, it is the narrator's job to make sure that the relevance of telling is clear. The narrator relies on the belief that there is a basic, shared understanding of the common world between himself and the story recipients. Within this world are people, objects, and occurrences.

Polanyi believes that the narrator has two tasks to accomplish. First, enough detail must be given so that the nature of change brought about is understood. Second, the narrator must differentiate between the various states and events, so that it is clear to the recipient what should be used to help infer the point being made. The teller arrives at this task through highlighting the most important information.

The strength of Polanyi's discussion of narratives, in relation to my study, concerns her beliefs on what the teller actually does in a narrative. This is something I will consider within my criteria of selecting narratives. One weakness in Polanyi's study is that she focuses mainly on what appears to be stories of extended length, instead of also including narratives of shorter length. In amplifying the discussion of storytelling, W. Lance Bennet explores the use of narrative as storytelling in a legal context.

In "Storytelling In Criminal Trials: A Model Of Social Judgment," W. Lance Bennet argues that storytelling is the most common form of discourse used to provide accounts of social behavior and human events. Through the telling of stories we are permitted to translate our impressions of a distant event into some sort of form that will allow a recipient in an immediate situation to grasp its significance. Bennet states, "Stories are powerful means of transmitting precise interpretations of distant and complex events to people" (3).

Bennet discusses several ways that stories are indicators of powerful cognitive processes. These include listeners' ability to take a story and "cross reference" it with personal information or experiences that they have stored for storytelling. Additionally, the power of stories is evident by the small number of facts that are needed in order to transmit an impression in story form of experiences and events. Furthermore, the power of stories is seen in the way that listeners are able to fragment together and repair poorly told stories. Regardless of the features stories possess, Bennett concludes that "stories are a central factor in communication and interaction processes of familiar situations" (4).

Bennett analyzes how stories organize information that help listeners perform three interpretive operations. First, the central action of the story must be able to be identified by the interpreter. Second, the interpreter must be able to make connections between the elements of the story that infringe upon the central action. Finally, the interpreter must be able to take the connections he makes from the elements surrounding the central action and test them to see if they make up a sufficient interpretation.

Although Bennet's writing focuses on storytelling in criminal trials and the effects on jurors, I did find some useful information on storytelling that can be applied to my narrative criticism of Measure 16 related narratives. I particularly agreed with Bennet's discussion of the impact stories have on the person interpreting them and how they are indicators of cognitive processes. While narrative communication is explored as a means of storytelling in varying situations, Gerald Prince discusses the issue of narrative in terms of its goals, contents, and elements.

In his discussion on narratives in Narratology: The Form and Functioning, Gerald Prince explains that the goals of narratology are to discover, describe and explain the mechanics of a narrative. This includes the elements responsible for its form and function. Prince elucidates that narratives can be categorized by such things as plot, narrator, and characters. These things combine to help give us a better understanding of human beings. Prince believes that narrative can be defined as possibly being the representation of real or fictive events and situations in a time sequence. He states, "Narrative is the collection of signs which can be grouped into various classes" (7). In written narratives there are a combination of certain features of signs which make up the narrative, therefore constituting narrating.

Within the narrative exists at least one narrator who may be more or less intrusive. The narrator is often designated by an "I." Additionally, there is at least one narrate, which may or may not be designated by "you". Typically, the narrator is the first person, the narrate the second person, and the object narrated about is the third person. Prince

argues, "The narrator may or may not participate in the events he recounts. In the case where he is a character, the narrator may play a less considerable role in what he recounts" (15).

Prince discusses the time factor that occurs between when a narration occurs and when it becomes a narrative. In written narratives the reader is usually not given too many hints as to when the narration occurs. Regardless of the time expanded between the narration and actual narrative, the narrator himself adopts a certain point of view in the presentation of the narrative. Prince concludes that there are three main types of point of views. *Unrestricted*, is the point of view (p.o.v.) acquired by the narrator when he tells more than any or all the characters could know. *Internal* p.o.v. occurs where all the information is presented strictly in terms of knowledge, feelings, and perceptions of one or several characters. *External* p.o.v. exists when the narrator presents everything strictly from the outside, including the appearance of the characters, their actions, and so forth--yet not including the characters thoughts or feelings.

Prince states that people with widely different cultural backgrounds frequently identify the same given sets of elements as narratives and reject others as nonnarratives. According to Prince, "there is generally widespread agreement about the fact that different narratives have different degrees of narrativity--some are more narrative than others, telling a better 'story' " (145).

Prince's work on narrative will be beneficial to my study of narrative as I will consider his beliefs and discussion on narratives as a whole, and the roles of the narrator, narrate, and other elements within a narrative. Overall, this source contains many strengths in the areas of explanation of narratives and related elements. Similar to Prince's exploration of the explanations and definitions of narratives, Michael Toolan discusses the issue of narrative--concerning its characteristics and related elements.

Narrative: A Critical Linguistic Introduction sets forth Michael Toolan's argument of what makes a narrative, especially a literary narrative, different [from any ordinary

speech event] is that the teller is particularly noticeable. "Narrative focuses our attention on to a story through the meditation of "telling" [by a teller], which we both stare at and through" (3). A distinctive characteristic of narrative concerns the source, or narrator, at whom we do stare at--rather than interact with on one level or another. The narrator is usually trusted by their addressees. He asserts his own authority to tell, to take the role of the knower or entertainer in relation to the addressee's adopted role of consumer of information. According to Toolan, "To narrate is to make a bid for some kind of power" (4).

Toolan states that there are typical characteristics found within narratives. First, there is included some degree of artificial fabrication or constructedness in the narrative that is often not found in natural, unconstrained conversation. Second, there exists some degree of prefabrication. This includes bits of information we have seen or heard, or think we have seen or heard before. Third, narratives seem to have "trajectory," or the expectation that they will move along with some sort of development. Fourth, narrative is a language communication like any other, requiring a speaker and some sort of addressee. Finally, narratives include the language feature, displacement. This feature is the ability of human language to be used to refer to things and events that are removed, in space or time, from the speaker or addressee.

Toolan discusses one area of controversy in narratives which relates to the interpretability of narratives. This controversy stems from the fact that narratives often stand alone, not embedded in larger "frames." There does not exist accompanying information about the author or intended audience which helps make the interpretability of the narrative easier for the recipient or addressee.

In Human Communication as Narration: Toward a Philosophy of Reason, Value, and Action, Walter Fisher (1987) discusses narrative as helping to enhance understanding of human communication and action wherever those forms of phenomenon occur. Fisher discusses how logos has been viewed within narrative for decades, with the term originally

referring to such devices as story, reason, conception, and discourse (1987, 5). Fisher states that since the time of pre-Socrates, Plato, and Aristotle there has been a great “contest” surrounding the use of logos and that there is merit in recalling and making use of original meanings attached to the ancient term (1987, 193).

Although Fisher distinguishes between forms of discourse in the way that some (discourse) are more trustworthy and reliable in respect to knowledge, truth, and reality, he believes that there exists no instances of communication privileged over another as a means of conveying knowledge, truth, or reality. In addition to the existence of logos with the human communication form, mythos is also imbedded in the narrative form. Mythos is referred to as ideas that cannot be verified or proved in any absolute way (1987, 19). Fisher argues that before philosophy existed in Greece, human forms in all modes were regarded as mythos/logos, form/content, and feeling/reason (1987, 192).

Fisher contends that narration is the foundation and conceptual configuration of ideas for the human species. “Narration is the context for interpreting and assessing all communication--not a mode of discourse laid on by a creator’s choice” (1987, 194). Fisher discusses deliberate structures that impose on our feelings and ideas within communication. These include introductions, climaxes, and epic/sonnet forms. Furthermore, Fisher argues that logic and good reasons come into play when anyone experiences an account that implies claims of knowledge, truth, or reality. The major principles of logic include coherence and fidelity. Reasons are said to be good when they are perceived as true and consistent to what we think, appropriate to whatever decision is pending, and promising in effects for both ourselves and others (1987, 194).

While Fisher’s views on narrative communication stem from antiquity, his thoughts and opinions merged to formulate what would eventually come to be known as a major breaking point in the discussion of narrative as a communication form. This breaking point was the evolution of the narration paradigm.

In his 1984 work entitled "Narration as a Human Communication Paradigm: The case of Public Moral Argument," Fisher introduced a new line of thinking in the area of narrative communication by presenting the narrative paradigm. According to Fisher, the narrative paradigm is "a dialectical synthesis of two traditional strands in the history of rhetoric--the argumentative, persuasive theme and the literary, aesthetic theme" (1984, 2). "Narration" refers to the theory of symbolic actions--specifically words and/or deeds that have some sort of sequence and meaning for the people who create or interpret them. "Paradigm" refers to a representation designed to formalize the structure of an experience, while understanding both the function and nature of the experience (1984, 2).

Fisher explains the two separate paradigms of human communication which he believes exists. These are the rational and narrational. Experts need the rational paradigm to conduct or account for their special fields of argument. The narrative paradigm has no necessary place in special fields, but publics need it to account for good moral arguments about major decisions of the day.

Fisher argues that human communication should be viewed as historical as well as situational. He believes that all human communication is narrated. Furthermore, the term "homonarrans" is suggested by Fisher as a metaphor for defining humanity. Fisher challenges the notions that human communication is considered rhetorical--must be an argumentative form.

Fisher discusses the existence of presuppositions to the narrative paradigm. First, humans are storytellers. Second, human decision-making and communication vary in form among communication situations, genres, and media. Third, the production and practice of good reasons is ruled by a variety of things--including the language action paradigm. Fourth, rationality of a coherent story and familiar experiences is determined by the nature of persons as narrative beings. Finally, the world is a set of stories made possible through a process of continual recreation.

The opinions and beliefs Fisher expressed in this essay created a pivotal shift in the area of narrative communication. This led the way for several of Fisher's colleagues to respond to his new found concept in various essays.

In the essay, "Narrative: Mode of Discourse or Paradigm?" Robert Rowland critically analyzes the work of Fisher, specifically that which relates to the "narrative paradigm." Although Rowland does not deny Fisher's work in the area of narrative discourse, he does suggest some limitations to the narrative paradigm. Rowland argues that narrative should include rhetoric that both explicitly tells a story and that implies a story. This belief differs from Fisher and other scholars who believe that "only rhetoric that tells a story can fulfill.....the function served by narrative" (273). Furthermore, Rowland concludes that we should not reject the "rational world paradigm" in order to study narrative. According to Rowland, "Fisher is correct that traditional rationalism cannot explain the rhetorical power of narrative. That power comes not from argument or logic, but from narrative form" (273).

Rowland discusses the problem of a narrative being defined so broadly to the point of losing its explanatory power. Rowland agrees with Fisher's labeling of narrative work as metaparadigm, yet he feels the narrative paradigm would be no assistance in evaluating a particular work if all forms of discourse are narrative. Additionally, Rowland questions whether the narrative paradigm is the answer for an alternative standard for rationality to "rescue the public sphere from the clutches of technical experts" (268).

Rowland does respond to Fisher's claim that his narrative approach to public argument is an alternative means of evaluating moral claims. Rowland states, "Unfortunately, while we do desperately need a new method of deciding questions of value, the narrative paradigm does not provide such a methodology" (271). While Rowland agrees with Fisher's assumption that there exists a certain set of idealistic, traditional liberal values, he believes they are not shared by all people. In addition to

Rowland's response to the narrative paradigm, there are other essays which set out to debate Fisher's "new line of thinking".

McGee and Nelson respond to Fisher and his sentiments regarding the narrative paradigm within their essay, "Narrative Reason in Public Argument." Although, McGee and Nelson agree with Fisher's beliefs on communities who reason through stories, they disagree with his contrast of reason to narrative--especially in public argument. The writers prefer a functional view of narrative practiced especially, not exclusively in politics. While McGee and Nelson agree with Fisher that technical arguments in special fields do differ from moral and public arguments, they disagree with the notion that narratives do not play a role in the discussion of experts. Overall, the writers argue that Fishers narrative paradigm is "unduly loose and problematical" (144).

McGee and Nelson believe that narratives do not need to be considered in a separate category of discourse. The writers state, "Narrative, even simple stories of 'then....and...then', have a power to communicate procedure that escapes the propositions of Fisher's scientist's" (150). McGee and Nelson argue that for a narrative to function as a "transforming agent" it must be compelling to an audience, which is enhanced via the myriad of beliefs which are already held by the audience.

The essay by McGee and Nelson is included in the literature review as another response to Fisher's narrative paradigm. While the writers both agree and disagree with aspects of Fisher's essay on this paradigm issue, there are alternative perspectives offered, such as the one proposed by Barbara Warnick.

In the essay, "The Narrative Paradigm: Another Story," although Barbara Warnick admits that the narrative paradigm has been "undoubtedly influential" she nevertheless expresses her own reservations. This includes that the narrative paradigm lacks "narrative probability"--or internal coherence and that Fisher's contradictory claims and statements about the paradigm are likely to cause difficulties for those who seek to apply the paradigm to texts.

Warnick argues that Fisher's attitude towards the "rational world paradigm" has changed over time and remains ambiguous, which affects the overall role of traditional rationality in critical assessment. Warnick states, "Fisher's attitude towards rationality has become decidedly less friendly and more ambivalent" (174). Furthermore, Warnick concludes that there are three major problems which arise when Fisher argues for the superiority of narrative rationality. First, Fisher has identified the rational paradigm with only one form, yet does not establish how successful or pervasive it is. Second, the traditional rationality that Fisher speaks of arose from his efforts to criticize it. Finally, Fisher's view of the rationality indictment results from his efforts to argue that narrativity is more comprehensible and accessible to the public--which should make it more valuable than rationality.

Warnick argues Fisher's position that people always prefer the "true" and "just" view by using an example of how successful Nazi propaganda persuaded the German people about the Jewish race. Warnick explains that because of the ambiguity and implicitness of claims, narrative can be used to account for seemingly discrepant facts. Such is the case with the Nazi propaganda. Warnick states, "This ambiguity of the traditional rationality in the narrative paradigm invites confusion on the part of the critics who seek to apply it to the critical assessment of texts" (176).

Warnick states that Fisher's discussion of the narrative probability, alone, is inadequate for the criticism of rhetorical discourse. This opinion emerges because narrative probability cannot enable one to make a choice between two or more equally coherent narratives--as Fisher suggests. Furthermore, internal coherence can not be a sole criterion because of the features which make it rhetorical (178).

Warnick states that Fisher has taken contradictory positions on issues that determine how the narrative paradigm is to be used to assess texts. Additionally, the paradigm lacks narrative coherence. Warnick believes that Fisher is unclear about traditional rationality in his model and he does not succeed in enlarging the circle of

critical evaluation. Warnick concludes by suggesting that the narrative rationality may be a system of critical criteria that may be varied in its use depending on the text being assessed

The issue of truth within narratives is discussed in William Lewis' essay, "Telling America's Story: Narrative Form in the Reagan Presidency." Lewis states, "Narrative theory can provide a powerful account of political discourse" (295). Lewis responds to Fisher's narrative paradigm by stating that from the view of the paradigm, "A story should be a good story judged by internal aesthetic criteria and by external criteria to 'fit' with the audiences' experience and morality." (281). This discourse includes Ronald Reagan's rhetoric, where story telling is fundamental to Reagan's relationship with his audience.

Lewis discusses two kinds of stories--anecdotes and myths--which exist in Reagan's rhetoric. Anecdotes are the "quick stories, jokes, or incidents that are verbal counterpart of the visual image" (296). Anecdotes help to define the character of an issue and act as the verbal counterpart of the visual image. They are intended to help create an interest, with their meaning established in relation to a large view of understanding. The relation, or reference, is either specified within the discourse or assumed in an audience. Myth refers to "any anonymously composed story telling of origins and destinies" (296). Myth is viewed as rhetoric which informs. A sense of importance and direction are provided by myths. Additionally, myths grant a communal focus for an individual's identity.

Lewis argues that events become meaningful in stories and the meaning depends upon the significance of the events within the story's context. Furthermore, the perception of truth depends upon the story as a whole, not the accuracy of individual statements. Lewis concludes that the narrative form shapes interpretation by emphasizing understanding. In other words, the understanding of a narrative is juxtaposed with how a person interprets the communicative act for her own self. Narrative receives its power from involvement of the audience as actors in the story.

Historical narratives are discussed as a story form which not only permits us to judge the moral significance of human projects, but also provide the means by which to judge them. This judgment occurs even when we pretend to be simply describing the narrative as persuasive discourse--as Lewis does with Reagan's discourse.

Finally, in her book, Rhetorical Criticism: Exploration & Practice, Sonja K. Foss (1996) states that a critic who uses narrative as the unit of analysis in a rhetorical study should focus on the story form. The critic may try to discover how the construction of a narrative directs the interpretation of a particular situation. Additionally, the narrative itself functions as an argument to view and understand the world in a particular way. When the critic analyzes the narrative, she can understand the argument being made and the possibility that it will be successful in gaining acceptance in the perspective it offers (400).

There are several useful principles drawn from the literature review, which will be incorporated into this study. Lucaites and Condit state that within a rhetorical narrative, the author, narrator, and speaker are treated as one. Additionally, Coste disputes that the narrator's task is to control the structure of the text. Furthermore, Prince argues that the narrator is the first person, often designed by the term "I." Genette discusses the idea that the participant within the narrative takes on a perspective, acquiring a "point of view" or "vision." Finally, Toolan states that the narrator makes a bid for some kind of power, by asserting his own authority to tell and take the role of knower.

Statement of Method

A contemporary approach to narrative, as explained in the literature review and illustrated by Sonja K. Foss, will be applied in this study as a method for investigating narratives pertaining to Measure 16 and the controversy of doctor-assisted suicide. After reviewing a plethora of modern views of narrative, Foss' approach works effectively in explaining the use of narratives as a means of influence within the public policy arena.

Foss' approach to narrative criticism involves the exploration of narratives used within the communicative act. Specifically, a comprehensive examination of the narrative is conducted by the critic. This includes identifying specific features of the narrative including, the setting, characters, narrator, and events. This study attempts to show that narratives, containing these elements, were created by the voter's of Oregon. Additionally, this study will illuminate the ways narratives help to create the narrator's worldview that others respond to and act upon at the voting booths. Finally, for purposes of this study I will utilize Foss' definition of narrative. Foss states, "A narrative is generally recognized as a way of ordering and presenting a view of the world through a description of a situation involving characters, actions, and settings" (400).

Foss states that the basic procedure a critic uses for conducting narrative criticism involves two steps. First, the critic examines the narrative in detail to gain a comprehensive understanding of the discourse, as a whole. This examination involves the various dimensions of the narrative which include the *setting, characters, narrator, events, temporal relations, causal relations, audience, and theme*. Secondly, the critic focuses on the aspects of the narrative which allow him or her to answer the research question that guides the analysis (402). For purposes of this study, the dimensions which are focused on in order to guide the analysis are the *setting, characters, narrator, events, temporal relations, and causal relations*.

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Chapter Two:

Contextual Ground: The History and Evolution of Doctor-Assisted Suicide

Throughout the ages, people have argued that when faced with unbearable suffering, killing yourself is an appropriate act. Under King Edgar, a tenth-century English ruler, suicide was not penalized if the act was performed due to ill-health or insanity (The Economist b, 21). While this exception may seem ludicrous, it illustrates the notion that the issue of suicide has been dealt with far before our time. Suicide has become a prominent issue many centuries later in the 1990s, because of the increasingly controversial debate involving doctor-assisted suicide and the rights of human-beings to prematurely end their life. Publicity surrounding the legality of doctor-assisted suicide has transformed it into a social issue, with varying public opinion. A central argument in the doctor-assisted suicide debate concerns whether or not individual states can make the practice legal by way of a state-wide election. Wherever one turns, heated activity within the assisted suicide realm is usually found. According to Wesley J. Smith (1997) a major reason for the noticeable activity concerning this subjective medical practice is that “within the last ten years there has been a major attempt to change the traditional Western ethic which views all people as being born with equal moral worth” (36). Therefore, this chapter examines the history of assisted suicide, leading up to the passage of Oregon’s Death with Dignity Act, by exploring the issue both within the United States and in other surrounding countries. Included is an exploration of alternative options to assisted suicide and a discussion of the key persons and groups involved within the assisted suicide debate.

In order to discuss the issue of doctor-assisted suicide it is important to distinguish it from euthanasia. The term euthanasia is derived from the Greek roots meaning “good death.” More specifically, euthanasia means the act or practice of intentionally, mercifully, and painlessly causing the death of a person suffering from serious injuries, system failures, or fatal diseases (Beauchamp, 3). In a broad sense, Tom L. Beauchamp (1995)

defines the term as “painlessly putting to death or failing to prevent death from natural causes in cases of terminal illness” (3). There are two forms of euthanasia, “passive” and “active.” The Economist (1997b) states that passive euthanasia concerns switching off respirators or other life-support machines, something which frequently occurs in hospitals. In most places, passive euthanasia is sanctioned by legislators and widely practiced by doctors (23). Juanita Reigle (1995) asserts that “Active euthanasia is actually administering the means of death to another person, such as injecting the patient with the drugs which would cause death” (61).

Tina Stevens (1997) asserts that the 1970’s Quinlan case is often viewed as the beginning of the right-to-die movement. The central figure of this movement is the body of legal cases expanding the patient’s “rights” to decline life sustaining treatment, medical professionals to withdrawal such treatments, and the requests of terminally ill individuals to receive assistance in dying (10). Lawrence Gostin (1997) states that since Quinlan, the courts have rendered more than 200 judgments about the lawfulness of medical decisions to intervene, or the failure to intervene, in the dying process (1523).

At the age of twenty-one, Karen Ann Quinlan was admitted to a New Jersey hospital after falling into a comma. Quinlan’s parents eventually asked that doctors remove the ventilator which kept Karen breathing, yet doctors rejected their request. Legal proceedings soon began. On November 10, 1975 the New Jersey Superior Court denied the Quinlans’ request. The New Jersey Supreme Court handed down *In Re Quinlan* on March 31, 1976 ruling that Karen Quinlan’s “right to privacy” now included the right to be removed from her ventilator. Stevens (1997) claims that *In Re Quinlan* did not mark the beginning of the movement to deal compassionately with terminally ill patients, but was the beginning of the movement’s turn towards the court room, legal hearings, and limitations of so-called “rights” (11).

In 1990, the United States Supreme Court heard the Nancy Cruzan case, which contained elements similar to the Quinlan case. In Cruzan, the Supreme Court

proclaimed, "This is the first case in which we have been squarely presented with the issue of whether the United States Constitution grants what is in common parlance referred to as a "right to die." Gostin (1997) states that the cases which proceeded and postdated Cruzan did not hold that patients possess a pure, autonomous right to decide the manner and timing of their death. Instead, the cases developed a narrower principle that patients possess a right to forgo medical treatment (1524).

Beauchamp (1995) contends that doctor-assisted suicide is usually considered a form of active (voluntary) euthanasia in the sense that the death is often both a suicide and doctor-assisted (4). The Economist (1997b) argues that this form of euthanasia is usually taken to mean that the doctor provides the know-how and means to commit suicide, but the patient is the one who actually takes the pills or pulls the trigger device on a machine that causes suicide with or without the doctor's presence (22). As Beauchamp states, "There is no conceptual requirement that the means chosen [to commit suicide] be as painless as possible. In these respects, assisted suicide is broader in scope than euthanasia" (4).

Before touching upon the history of assisted suicide within different parts of the world, it is important to discuss the varying arguments which surround the issue of assisted suicide. With strong support from both proponents and opponents of potential physician-assisted suicide laws, it is expected that conflict exists between arguments for and against assisted suicide legalization. People representing each side of the assisted suicide issue offer a variety of arguments and opinions. The following discussion represents some of these most consistent arguments.

A central argument offered in support of assisted suicide is based on a patient's autonomy, or self-determination. Allen Buchanan (1996) states that proponents of potential suicide laws simply believe that an individual should be allowed to control his or her own life. This control is not to exclude the course of death. The ability to choose when to die allows a patient to continue controlling the important aspects of human

existence (32). Another argument by those favoring assisted suicide is based on a patient's self-being, including the principles of nonmaleficence, the obligation to do no harm, and beneficence, the duty to do good. According to Amy Haddad (1997) "When the methods used to control chronic pain in patients are no longer effective, death becomes an alternative" (17). Additionally, Haddad contends that if a person is refused the means of death not only is he or she being denied something which could end suffering, but she or he is faced with the threat of enduring serious pain. As such, this treatment ignores a compassionate alternative to which a patient should have access (17).

In opposition to the arguments by those who favor assisted suicide, there are the arguments opponents propose against the controversial practice. The first of these arguments concerns religion and the sacredness of life. Although there are accounts of suicide in The Bible mentioned in the debate, opponents of assisted suicide state that taking a human life is to demean the value of life. Haddad (1997) asserts that because killing is morally wrong, opponents argue that health care professionals should not participate in an activity that will end someone's life (18). This leads into another argument proposed against assisted suicide, pertaining to the societal rule that it is wrong to take a life. Assisted suicide involves taking a life and opponents believe this practice is murder disguised by the term assisted suicide. Reigle (1995) maintains that opponents also argue that legalizing assisted suicide will weaken the commitment society has made towards providing care for the dying. While alternatives such as hospice care and pain control would not be promoted, the patient may not really wish to be killed. Yet, he or she may feel that because of the lack of societal and family commitment, suicide is the only available option (58).

The argument against assisted suicide that has received a considerable amount of attention involves the "slippery slope" debate. This "slippery slope" argument has been discussed in terms of two parts, with the first concerning where the "boundary" lies. This boundary refers to the issues of time and terminal illness. The Economist (1997b)

contends that it is hard to know where the boundary lies. Should the patient be a certain number of days, weeks, months, or years away from death before help is to be given? Additionally, if the criteria for assistance in suicide concerns patients who are terminally ill, what should the definition of "terminal" be (22)? Each of these issues involves the question of where to draw the line and when to do so.

The counter part of the "slippery slope" argument relates to the possible danger that could exist if the prohibition against killing were lifted. Many view assisted suicide as the start of a slide into condoning euthanasia in situations that include the frail and handicapped, and in terms of the care and assistance given by the professionals involved. Haddad (1997) maintains that although health professionals would initially be careful that every case of assisted suicide was appropriate and that other problems such as pain and depression were not included in a assisted suicide situation, this careful involvement by doctors could eventually decrease. As time progressed, those involved with the assistance of suicide may not be as attentive with every case, ensuring what would be appropriate under the potentially-approved assisted suicide law (18).

The variety of arguments both for and against assisted suicide stirred controversy before any law had been passed to legalize the practice. Simultaneously, another major dispute receiving vast concern and attention also preceded the legalization of assisted suicide. This situation involves one person, Jack Kevorkian, and his ability to illegally take part in helping people prematurely end their lives.

Jack Kevorkian, MD, an unlicensed pathologist, is the most prominent example of unregulated physician activity involving assisted suicide--something that many fear will become widespread once physician-assisted suicide were legalized (Beauchamp, 18). Kevorkian's mission in life is to pioneer radical change in the way human beings die. He advocates a society that allows euthanasia for the dying, the mentally ill, disabled, and infants with birth defects. Kevorkian sanctions experiments prior to a person's death and foresees a future involving organ harvesting. Kevorkian began experimenting with death

early in his career when he practiced photographing the eyes of dying patients. It was during this time that he earned the nickname "Doctor Death" (Betzold, 22).

Everything that Kevorkian has been involved with since his first assisted suicide in June of 1990 seems to stir up controversy. Yet, it is the invention of his suicide machine and the vast number of people that he has helped commit suicide, which has made him something of a household name across the country. Kevorkian's machine is the means by which his string of assisted suicide patients have been able to commit the life ending act. The suicide machine was constructed so that a tube is inserted into the arm and saline is allowed to flow. A button is pressed which injects other drugs into the body, eventuating potassium chloride--the cause of death. It is this very machine that Kevorkian's most famous first case, Oregon resident, Janet Adkins, had read about in the newspaper. Motivated to the point of flying to Michigan to meet Kevorkian, Adkins requested assistance in ending her life from the pain of dealing with Alzheimer's disease. After Kevorkian hooked the machine to Adkins, it was she, herself, who pushed the fatal button. At this point, Kevorkian had marked a spot in history (Beauchamp, 18).

Michael Betzold (1997) states that since 1990, Kevorkian has facilitated the deaths of at least 45 people within the boundaries of the state of Michigan (22). According to Smith (1997) the typical victim has not been terminally ill, but disabled and depressed, with autopsies showing that at least four people had no identifiable diseases at all (37). While few Michigonians seem to object to Kevorkian's involvement in such deaths, it is the Michigan legislature which is frustrated at the inability to devise a statute which would prohibit deliberate killing. Betzold maintains that although Kevorkian has been tried in court on several occasions for his involvement in the assisted suicide deaths, he has been acquitted each and every time by the help of his attorney, Geoffrey Fieger (24).

Jack Kevorkian represents one alternative to the legalization of physician-assisted suicide. Yet, there are other options one may chose instead of assisted suicide. The first of these options concerns choices a patient may choose as a way of ending his or her life

by refusing treatment. These alternatives include the voluntary stopping to eat and drink (VSED) and terminal sedation. Additionally, the option of hospice care is available for persons not wanting to prematurely end their life.

With VSED, a patient who is physically capable of taking nourishment makes the decision to stop all oral intake of food and liquids. This gradually leads to voluntary death due to dehydration or some other complication. Derek Humphrey (1991) expounds that the patient's pre-existing condition determines how long the process takes. A fit human can usually fast around 40 days before life is seriously threatened (63). VSED protects patient independence and privacy to the fullest extent, as it requires no physician's participation in the act. Unfortunately, VSED may last for weeks and could increase a patient's suffering due to lack of hunger and thirst. Timothy E. Quill, et al (1997) maintain that if a physician is not involved in the process, treatable depression may be missed and the patient may lose mental clarity towards the end of the process (2099). Humphrey believes that in cases where the patient is in a persistent vegetative state, starvation causes no pain as long as there is good nursing care (64).

According to David Orentlicher (1997) terminal sedation transpires when a suffering patient is sedated to unconsciousness. This usually occurs through the administration of barbiturates, with the patient dying of dehydration, starvation, or some other complication. In this situation, all life-support treatment is withheld. Because patients are sedated during this period they are said to be free from suffering, although death takes anywhere from days to weeks to occur (1236). Quill (1997) states, "While terminal sedation has been argued to be something 'foreseen,' it is not 'intended' since sedation itself does not cause the death. Instead, sedation is intended to relieve suffering" (2100). Terminal sedation has the advantage of having a time delay between its initial start and death, which is beneficial to a person who may have second thoughts to using the process. Quill believes that the practice of terminal sedation is controversial, in that it has many risks associated with physician-assisted suicide (2100).

One of the most widespread options urged for patients dealing with illness and death, in place of opting for assisted suicide, is hospice care. The Economist (1997a) declares, “Almost nine out of ten healthy Americans agree that dying at home, in comfort, is the ideal situation”(32). While these are the views of Americans, it is unfortunate that hospice use is considered an admission of defeat by doctors and family. Fish (1997) contends that what many physicians and families overlook is the idea that hospice offers the hope that death does not need to be painful or impersonal. Furthermore, hospice shows that while death may be inevitable it does not have to be unendurable (109).

Hospice is the only medical program designed exclusively for the dying. A patient who is given six months or less to live and agrees to hospice care is required to give up aggressive treatment of their disease. According to Humphrey (1991) aggressive treatment includes no life-support equipment, such as respirators or artificial feeding. Typically, the patient is not cared for in a hospital or nursing home, but is at home with a hospice team of physicians, nurses, nurse’s aides, and social workers (35).

Fish (1997) claims that the nation’s 3,000 hospice programs currently tend to some 15 percent, or 390,000, of American’s dying each year. Unfortunately, even with such huge numbers, hospice have still been faced with the same major obstacle since the first American program opened in 1974 (111). This obstacle concerns the reluctance of physicians to send patients to hospice, as it signals an admission of defeat. Fish states, “Doctors offer more treatment help, instead of facing the idea that there is no hope left for the patient” (111). Besides doctors, patients and their families are often reluctant to use hospice. Instead, the patient or his or her family insist on continuing treatment and hesitate to sign consent forms required for hospice care.

The Economist (1997a) argues that while Medicare paid more than \$1.9 billion on hospice care in one year [1995], under existing policy it will reimburse the cost of hospice only if a doctor certifies that the patient has less than six months to live (32). This results in patients waiting until almost near-death before they enter hospice. Ira Bydrock,

president of American Academy of Hospice and Palliative Medicine, believes that what Americans want to avoid is dying in pain. They do not want to die isolated and abandoned, or become a financial burden on their families (Fish, 109). With the current situation of Medicare and hospice, these fears could become an unfortunate reality.

Luckily, policy is directed towards the encouragement of hospice care for terminally ill patients. The Economist (1997a) asserts, "Reformers would like two changes regarding the issue of hospice. These include allowing patients to leave hospice care and return at any time and more flexibility with the six-month rule, depending on the patient's condition" (32).

While other options to assisted suicide are known and practiced, the desire for aid-in-dying through assisted suicide has been widespread across many nations for decades. Before the United States recently entered into the debate, other nations dealt with the issue as an illegal practice--used in what almost appears to be a legal manner.

As the discussion of doctor-assisted suicide stirs up controversy in the United States, attention is increasingly given to the Netherlands and its use of this debatable practice. Within the Netherlands, doctor-assisted suicide is discussed and practiced much more openly than any other country. Beauchamp (1995) maintains that "approximately two percent of the deaths in the Netherlands are acts of voluntary euthanasia involving a doctor's assistance" (19). According to The Economist (1997b) although euthanasia is technically illegal in the Netherlands, doctors who follow strict guidelines, such as making sure the patient really wants to die, have been protected from prosecution for the past two decades (24). Specific guidelines called "rules of due care" were implemented into a statute June 1, 1994. These guidelines consist of questions the physician is expected to answer when reflecting upon whether his actions were appropriate when providing euthanasia (Battin, 89). Under Holland's national legislation and system of supervision, a patient's request to end his life must be authorized by the state and medical authorities. Beauchamp (1995) alleges that a justified euthanasia consists of an informed request by a

patient who is suffering from unbearable pain, a consultation with a second physician, and a careful review of the patient's condition by the physician performing the euthanasia procedure (19).

Many people are under the misconception that euthanasia is practiced daily in the Netherlands, when in fact it is somewhat rare. The Economist (1997b) declares that Dutch doctors do indeed receive a large number of request for help in dying--9, 700 in 1995--yet they do not respond to each and every request. In 1995 only 2.4% of deaths from the nearly 10, 000 requests were active euthanasia. The percentage for doctor-assisted suicide was 0.2% (24). Margaret Battin (1994) states, "The actual frequency of euthanasia is about 1 in 25 deaths that occur at home, around 1 in 75 hospital deaths, and about 1 in 800 for deaths in nursing homes" (92).

While the Dutch assisted suicide experience is referred to in the United States by both opponents and proponents of potential assisted suicide laws, it was not until between 1991-92 that an ample amount of data was available concerning the practice of euthanasia in the Netherlands. During this time period two major studies of the actual practice of euthanasia in the Netherlands were published. Battin (1994) claims that both studies attempted to discover what Dutch doctors actually do, and do not do, as their patient's begin to die. Additionally, the studies explored the frequency of euthanasia in the Netherlands while gathering information about the patients and the nature of their request for euthanasia (95). The two studies came quite close in their estimates of the overall frequency of euthanasia in the Netherlands. Of the roughly 2, 300 cases of euthanasia each year, about 1,550 are performed by general practitioners, 730 by specialist physicians, and around 20 by nursing home physicians (96).

In addition to the Netherlands, other neighboring countries of the United States have their own particular thoughts, opinions, and laws pertaining to assisted suicide. In his article, "Views of assisted suicide from several nations" Pat Phillips (1997) examines the varying viewpoints of this controversial issue. Although Canada prohibits

doctor-assisted suicide by the federal crime code, the province of British Columbia is allowed to make an exception to that code. As in the Netherlands, the province of British Columbia has set guidelines for “prosecutorial discretion dealing with assisted suicide” (969). This refers to specific circumstances where no prosecution occurs for doctor-assisted suicide. In 1995 the Canadian Senate organized a committee to study the issue of doctor-assisted suicide. In a four to three decision, the committee opted to continue the prohibition of assisted suicide. The Canadian Senate and Supreme Court did unanimously decide that a clarification to the law was necessary concerning withdrawing and withholding life-support treatment (969).

In England, the Suicide Act containing the principles involved in assisted suicide was created in 1961. Although it is not a crime to commit suicide in England, it is against the law to aid and assist suicide. While prosecution occurs if one aids in ending another human life, the legal system has acknowledged the need to clarify the law within specific instances. There have been at least two particular court cases in England which have helped draw a distinction between the participation in assisting a suicide and withdrawal of life support. Although England presently views assisted suicide as an illegal act, some argue it is simply because the country can not accept any other position. Christopher Newdick, professor of law at the University of Reading, states “In England, the law cannot face the prospect of saying it is a duty or right of a doctor to end a human life” (967).

The Northern Territory of Australia has adopted a statute, Rights of the Terminally Ill, as a means of allowing doctor-assisted suicide to become a legal practice within the country. Although the statute was passed in 1995, it was overridden by Australia’s national parliament putting its legal status on hold at the present time. The Northern Territory statute requires that the patient has a terminal illness, with no specific time limit set on the person’s death. A second doctor, who must be trained in treating depression, is required to give a second opinion to the patient. Additionally, a doctor is to be present at

the time of the person's actual suicide, possibly even administering the lethal substance. The statute itself emphasizes "professional beneficence" (967).

The definitions of doctor-assisted suicide and the laws pertaining to the practice vary from one country to the next. It is important to be aware of the stance taken by other countries on doctor-assisted suicide because both proponents and opponents of suicide laws within the United States have based many of their ideas and conclusions on the assisted suicide practices of other countries. Although the intervention to end the life of a patient has actually been practiced both legally and illegally around the world for decades, it is only within the last several years that the United States has found itself in the midst of turmoil. This turmoil has been partially created from the way that individual states have proposed initiatives to make doctor-assisted suicide a legal practice. Interestingly enough, in the United States the assisted suicide debate has been focused among the Pacific coast states. Laws have been proposed unsuccessfully in California and Washington, and with Oregon's passage of Measure 16, it became the first assisted suicide law in the world.

One of the first laws proposed in the United States concerning euthanasia and doctor-assisted suicide appeared in California in 1988. Smith (1997) contends that during that year, an initiative was circulated by advocates of euthanasia to make it legal for doctors to administer lethal injections to end a patient's life. Unfortunately for proponents of the initiative, the effort failed as there were not even enough signatures obtained to put the initiative on the ballot (37). Following this attempt in California, advocates for assisted suicide focused their new effort on the voters of Washington state.

Washington state voted on Initiative 119 in 1991. In order to put the initiative on the November 1991 ballot, proponents collected more than the required 150,000 signatures needed. If it had passed, Initiative 119 would have amended the state's natural-death act and allowed physicians to aid others in dying. Peter McGough (1993) states that the use of the vague phrase, "physician aid in dying" was confusing to physicians and the public alike. The phrase represented a wide range of situations and was

defined as a medical service provided in person by a physician that will end the life of a conscious and mentally competent qualified person in a dignified, painless, and humane manner, when requested voluntarily by the patient through a written directive executed at the time the service is desired (63). The request for a physician's aid in dying was to have been made in writing by the terminally ill patient in the presence of two independent witnesses. Furthermore, there were to be two physicians who would have independently examined the patient. Each physician was required to certify in writing that the patient had a terminal illness likely to result in death within six months.

Robert Misbin (1991) argues that the people of Washington might have voted on Initiative 119 on the basis of its effect on the practice of medicine within the state. While a person may believe that there are justifiable circumstances to intentionally kill a terminally ill patient, the same person may be against an assisted suicide law on the basis that it could have negative effects on the care of other patients, the medical profession, and society (125).

On November 5, 1991 Washington voters turned down Initiative 119. Groups such as the American Medical Association opposed the initiative stating that the profession would not change its position anytime in the near future (McCormick, 133). Misbin discusses several questions that were important to consider before casting voting ballots for Initiative 119. These questions include how would this type of law affect the terminally ill? If a physician could aid another in dying, would patients feel obligated to request this type of help instead of burdening their friends and family? Additionally, if such an initiative were passed, would it lead to involuntary euthanasia? Specifically, would the right to end a human life extend to incompetent patients as well? Some argue that allowing physicians to aid in ending human life would lead to desensitization of the value of human life. Furthermore, physicians may become desensitized to human suffering if they feel denied the legal means to alleviate that suffering. Finally, does a physician's aiding in the death of a patient contradict a physician's role as a healer? Many believe that

the killing of a patient by a physician is inconsistent with the physician's role as a healer. Yet, if a physician tries to persuade the patient to find other ways to deal with the pain and the patient insists on ending his or her life, the physician is put into an unreasonable position.

Although citizens pondered many types of questions and issues regarding life and suicide, both before and after the voting of Initiative 119, the proponents of assisted suicide refused to give up hope. They felt that voters in some state would stop the consistent pattern of denying legalization of assisted suicide. With this in mind, advocates of assisted suicide returned to California.

In November of 1992, the people of California saw an initiative involving assisted suicide actually reach the ballot. Voters were introduced to Proposition 161, the Terminal Illness Assistance-In-Dying initiative, which was very similar to Initiative 119 from Washington state and was supported by many of the same "death with dignity" groups as in Washington. The proposition would permit doctors to assist those patients who had made a written request for dying. Already implemented was The California Natural Death Act of 1976 which established the right for persons to refuse all unwanted interventions. This act made it illegal in California to prolong the act of dying against the will of a patient (California Voters Pamphlet, 1992). Leon Kass (1992) maintains that Proposition 161 differed from the Natural Death Act because the initiative intended active euthanasia, or the deliberate, direct killing of a patient by a physician--as well as assisted suicide. Unfortunately for proponents, some viewed the initiative as a way of simply placing the physician into a role as a technical dispenser of death (46).

Just as Washington's Initiative 119 consisted of specific elements laid-out by advocates, Proposition 161 was made up of specific guidelines under a certain criteria. If passed as law, any patient under Proposition 161 needed to express an "enduring request for aid-in-dying" with "enduring" defined as "expressed on more than one occasion." The patient requesting deadly assistance was to have a "terminal condition," meaning "death

within six months or less.” A physician would have the option of obtaining a psychological assessment to ensure the patient’s competence, yet was not obliged to do so in every situation (California Voters Pamphlet, 1992). According to Kass (1992) the initiative amended the state penal code so that aid-in-dying would be exempted from the law that makes aiding, advising, or encouraging of another to commit suicide a felony. Yet, while doctors could encourage patient’s to end a life, they would not be allowed to “coerce” someone (47). Additionally, hospitals and physicians would be required to keep clear, concise records and report information concerning euthanasia cases to the health department. This information would only be statistical, as the initiative stated “the identity of the patient shall be strictly confidential and shall not be reported” (48).

Once California voters cast their ballots on the assisted suicide issue, the same results emerged as in the previous year in Washington state. Proposition 161 had been rejected. While the initiative’s failure continued to add to the frustration of assisted suicide advocates, it also stood as a turning point for supporters. There was a definite need for a new strategy. Courtney Campbell (1994) asserts that when looking at the proposed initiatives in both Washington state and California, advocates of assisted suicide laws learned several lessons. First, there was the perceived notion that Initiative 119 and Proposition 161 had each stretched the comfort levels of voters too far too fast, as the concept “physician aid in dying” incorporated several issues under one label. Also, the preferred approach for the passage of legislation was to have a direct appeal to the voters through the initiative process (142). Finally, the language of the initiatives needed to focus on patient choice, while trying to avoid the term “assisted suicide” whenever possible (143).

With a fresh approach in mind, assisted suicide proponents drafted Measure 16, known as the Oregon Death with Dignity Act, in 1993. According to Campbell (1994) the process was almost abandoned at one point because of disputes between members of the Oregon Right to Die Coalition and the Hemlock Society who disagreed over the actions

that physicians would be allowed to take and the waiting period between a patient's request and the physician's compliance (143).

Anne Fadiman (1994) states that the Hemlock Society, a major player in the euthanasia movement, was formulated in Los Angeles in the summer of 1980 by British journalist, Derek Humphrey, and his wife Ann Wickett (75). The First Amendment was the Hemlock Society's shield and the Society's counsel advised Humphrey to spread his "gospel" through the use of printed word. With this idea in mind, the *Hemlock Quarterly* was born. Along with the 53 issues that were published over 13 years came an increase in number of subscribers--from 443 in 1980 to 39, 463 in the final year the *HQ* was printed (76). In the fall of 1989, Humphrey resigned from his positions as executive director of the Hemlock Society and editor of the *Hemlock Quarterly*, after his wife committed suicide by swallowing a fatal dose of barbiturates. In 1991 Humphrey authored the best selling book on "self deliverance" entitled *Final Exit*, which became considered as something of a "how-to-do-it" suicide manual (Carr, 50). Two years later in 1993, Humphrey published *Lawful Exit*, which consisted of the history of euthanasia-law reform. Campbell (1994) asserts that with the publicity that Humphrey received from his involvement in the Hemlock Society and writing books, he became known as something of a visible figure among the death with dignity advocates (143). Humphrey's support of Measure 16 was something advocates knew they needed. Patricia Roberts (1997) contends that although Humphrey argued for lethal injection, stating that the pills-only law would work only if doctors stood by to administer the "coup de grace if necessary," he eventually gave his support to the drafted plan of Measure 16 (64). Humphrey's support came largely in the way of appealing to national right-to-die organizations for financial support.

Organizations like the Oregon Right to Die Coalition and the Hemlock Society received ample amounts of attention as major proponents of Measure 16. Another visible player for the proponents of assisted suicide was Barbara Coombs-Lee, a physicians

assistant, attorney, and executive director of Compassion in Dying, a nonprofit organization in Seattle (Brock, 25). As a chief petitioner of the Oregon initiative, Coombs-Lee believed passive euthanasia occurred all the time. Art Moore (1997) declares that with the passage of a law such as Measure 16, Coombs-Lee felt that aid in dying had the potential, for the first time, to add the patient's desires and sensitivities to the decision-making process (52).

While the formal announcement of the Death with Dignity Act came in December of 1993, opposition to the potential law grew largely during the months prior. The Oregon Catholic Conference began to coordinate the Coalition for Compassionate Care organization, and the church became a financial focal point for opponents of Measure 16 (Campbell, 145). Maureen Hovenkotter (1994) states that in a controversial move, the Roman Catholic church began an in-pew collection which staunch allies believed may have crossed the line separating church and state (6). Although seeking political contributions in church was unprecedented in Oregon, a church collection by California Catholics had also helped to defeat Proposition 161 in 1992 (7).

In addition to the involvement of the Roman Catholic church within the realm of the assisted suicide issue, the Oregon Medical Association found itself in the midst of heated activity pertaining to Measure 16. Campbell (1994) claims that physicians opposed to the measure requested that the OMA reaffirm opposition to physician-assisted suicide and Measure 16. The OMA instead opted for neutrality on the issue. This position by the OMA not only represented a departure for the organization from the American Medical Association, but also other associations in Washington and California (147).

Roberts (1997) maintains that in the end a vast number of organizations opposed Measure 16 including the Oregon Catholic Conference, Oregon Right to Life, and the Oregon Association of Hospitals and Health Systems (64). Campbell (1994) asserts that in July of 1994, more than the 66,771 necessary signatures were collected in order to put

the assisted suicide initiative on the ballot (146). Thus, the Death with Dignity Act was qualified for the general election in November.

The specific wording of the question proposed under Measure 16 asked, “Shall law allow terminally ill adult Oregon patients voluntary informed choice to obtain physician’s prescription for drugs to end life?” What the Death with Dignity Act would allow for is the ability of terminally ill patients to make a written request for a prescription for medicine to end their life. The patient must be an adult who is capable of making medical-related decisions. The patient must first request for assistance with suicide in writing, with the request made in the presence of two individuals. These persons are to act as witnesses, attesting to the fact that the patient is acting voluntarily and not being coerced by anyone in anyway. Only one of the witnesses may be a relative or heir (Carr, 54). The second request is to be made fifteen days after the initial written request. This second request is to be repeated orally to the physician. The physician must ask the patient to notify his or her family of the request for assistance in suicide, yet the notification is not a requirement in order for the patient to get a physician’s assistance. After the second request, a patient must wait an additional 48 hours before the actual prescription can be filled. At any time, the patient may revoke the request for suicide assistance (Alpers, 483).

A provision of Measure 16 is that a qualified patient must be at least 18 years of age and diagnosed with a terminal condition. The Oregon act defined terminal disease as one leading to death within six months, although determining a patient’s prognosis is often difficult and mixed with uncertainties (Alpers, 484). Campbell (1994) claims that because Measure 16 defined terminal illness more broadly than prior Oregon legislation, opposition to the initiative argued that a misdiagnosis could occur in the amount of months, even years, a person may have left to live. Yet, in contradiction to this claim, others felt that the criteria of six months was too restrictive (152). Ann Alpers (1995) maintains that a major concern [with Measure 16] involved the idea that compassion may move some

physicians to try and help patients with suicide assistance who are not terminally ill. Honesty is important in a physician-patient relationship as patients depend on their physicians for complete and truthful information. Therefore, a prognosis of less than six months for a person suffering is not justification for assistance in suicide (484).

Besides the broadness in the definition of terminal illness under Measure 16, questions and concerns also existed with the way the initiative defined “residency.” Under the Death with Dignity Act nonresidents of the state are excluded, yet the act does not define the requirements of residency. According to Campbell (1994) because of this vagueness, opponents believed that “Oregon would become a magnet for persons seeking physician assistance in death” (153). According to the Oregon Supreme Court, residency in Oregon is usually determined on the basis of intent to reside permanently in the state (Alpers, 484). Campbell claims that this includes times where there is the absence of a specific context, or when there is no legal precedent--as with assistance given to terminally ill patients (153).

While these were two of the issues that raised concerns about the effectiveness of Measure 16, proponents of the initiative were quick to point out many critical safeguards that were included in the proposal presented to the voters of Oregon. The safeguards were implemented as a means of ensuring the patient’s informed choice of suicide assistance. They include that the physician must disclose information about alternatives so that patient understand their choices, once a request for assistance has been made. Additionally, the attending physician and consulting physician must each make independent evaluations of the patient’s decision-making ability--specifically if the patient is suffering from impaired judgment due to depression or mental illness (Campbell,155).

The physician not only played a key role in the safeguards proposed in Measure 16, but along with the patient, is the other “central figure” in the potential suicide act. Because of the potential for undue pressure physicians could face if a suicide law were passed, the Death with Dignity Act specified that physicians would not be required to give

qualified patients medicine to end their lives. Within the initiative were specific provisions designed for the physicians. These include that if a physician decided not to take part in a request for suicide assistance, the patient would be transferred to another and the physician would withdraw from the case (Alpers, 485). Also, physicians would be limited to writing the prescriptions for the patient. While the physician would be considered a direct agent of death under the act, physicians themselves would understand that they would be indirect participants in a death chosen by the patient. Finally, a physician who participated “in good faith” under the authority of Measure 16 would be immune from professional, criminal, or civil liability (Campbell, 156-57).

Because assisted suicide may conflict with the mission of some health care organizations, “no health care provider” was to be under any duty to participate in any suicide. This included institutions such as hospice programs, hospitals, and nursing homes. At the same time, the act did forbid an institution from revoking the privileges of medical staff who might provide prescriptions for lethal medication (Alpers, 486). But psychiatrists, pharmacists, and nursing home staff were not specifically mentioned in Measure 16.

While the Death with Dignity Act posed many difficult questions for physicians and the healthcare industry as a whole to consider, Oregon voters had their own values and beliefs to consider at the voting booth. If Measure 16 were passed, history would be made as Oregon would become the first place in the world to legalize physician-assisted suicide. Yet after the failure of initiatives in Washington and California would Oregon voters also refuse to legalize such an act? On November 8, 1994, as assisted suicide proponents and opponents eagerly waited, Oregonian voters cast their ballots. By a slim margin of 51 to 49 percent, Measure 16 was approved (Moore, 51). With the passage of assisted suicide, there was no longer a question of whether this act would ever become legal. Instead, people wondered how the law would work and if there were other states to follow. Unfortunately for Measure 16 proponents, the celebration of legalized assisted

suicide was short-lived. A federal district court issued an injunction delaying the implementation of the law until the court could decide on several constitutional challenges the measure posed (Alpers, 483).

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CHAPTER THREE:

A Critical Examination of Rhetorical Narrative Function in Measure 16--Death With Dignity--Related Discourse

This chapter presents the analysis of the artifacts from the study of Measure 16, Death with Dignity, related discourse. The narrative agendum Sonja J. Foss (1996) presents in her book Rhetorical Criticism: Exploration & Practice, provides the method for my analysis. Within Foss' procedure are eight dimensions of a narrative a critic explores as a means of achieving a comprehensive examination of any narrative discourse. These dimensions include the setting, characters, narrator, events, temporal relations, causal relations, theme, and audience. Foss offers specific questions within each area that the critic may answer as a starting point for analyzation of the discourse. The following information is a summary of the questions within each of the eight areas.

When examining the *setting* of the narrative, the critic determines the scene within the narrative and whether it stays consistent or changes within the discourse. The critic studies the scene for its detail, development and the way it relates to the plot and characters within the narrative (402).

The critic investigates the *characters* within the narrative to determine the main characters of the story and their physical and mental traits. The critic should conclude whether the characters are flat (having only a few dominant traits) or round (having a variety of traits, some possibly contradictory or conflicting) in presentation (402).

There are several features the critic investigates when analyzing the *narrator*. This includes determining if the narrative is mediated by the narrator or presented directly to the audience, what items in the narrative create the narrator's presence, and what kind of person he or she appears to represent (402). Additionally, the critic examines what type of vocabulary the narrator uses, how vividly the story is told, and the narrator's overall attitude toward the story. The critic explores what type of authority the narrator

claims to have and if she or he goes beyond describing events to interpret and evaluate situations. Finally, the critic takes note as to how reliable the narrator seems to be and if he or she allows the narrative to range into the past and future or if the narrative stays within the moment of the story (403).

The critic assesses how the *events* of the narrative are presented. This involves looking for the major and minor events of the story and how they relate to the plot lines. The major events are known as kernels, while the minor events are satellites (404). Within this study of narratives, the narrators usually discuss their opinions and beliefs on a variety of issues. The reader often views these discussions as constituting either a major or minor event within the narrative. Yet, this type of “event” is not defined by space and time. For this reason, an extended definition of *events* will be used in this study.

The critic needs to examine the *temporal* and *causal relations* among events of the narrative. *Temporal relations* include if the events occur in a brief period of time or over many years. Also, if events occur in present tense entwining the action the reader views or in past tense by use of flashbacks and flashforwards. *Causal relations* refers to the cause-and-effect relationships the narrator establishes in the narrative. This includes connections made between the causes and the effects and how strong and clear the connections are made (404).

The *audience* is what person or people the narrator is addressing the narrative. The critic determines whether this is a group, individual, or even the narrator him or herself by possible signs given in the narrative (404).

The critic determines the *theme* of the narrative through the general idea of what he or she believes the narrator is illustrating in the story. Several themes appear in narratives including those involving good and evil, success and hard work, and oppression and violence (405).

For purposes of this study of Measure 16 related discourse, I will be utilizing six of the eight dimensions of Foss’ agendum. The dimensions of *audience* and *theme* are not

found in this study due to their consistency among the artifacts. The *audience* for each narrative was potential voters of Measure 16 in Oregon's state wide election in November of 1994. The audience within the secondary category of sources still includes the potential voters of Measure 16, but now focuses on the members of the Oregon Legislature involved in the attempted repeal of the passage of Measure 16.

The *theme* of each narrative varies according to which side of the issue of doctor-assisted suicide the narrator represents. If the narrator represents the proponents of assisted suicide, the theme of freedom of choice exists. The narrators representing the opponents of assisted suicide typically write narratives containing themes that depict assisted suicide as being immoral and unjust. These themes differ in content in comparison to the major arguments offered by opponents of the assisted suicide debate. As discussed in chapter two, these arguments concern religion and the sacredness of life, and the societal rule that it is wrong to take a life. Because of these reasons, the dimensions of *audience* and *theme* are not found within the analyzation of the artifacts.

The following critical examination of narratives is divided into two categories. The first category is made up of discourse from the 1994 Oregon Voters Pamphlet. This includes arguments by Oregon residents who favor doctor-assisted suicide in Oregon and those against the practice. The second category of sources are letters from Oregonians sent to Representative Jo Ann Bowman and other government officials; along with a letter sent to the Editorial department of the *Oregonian* newspaper, which was simultaneously sent as a letter to Representative Bowman.

Narrative One

Setting

Patti Rosen, the narrator and mother of cancer victim, Jody Rosen, creates the scene within the narrative. The scene consists of the narrator's discussion of events from

Jody's life which lead to her request for assistance in suicide as a means of ending her battle with terminal bone cancer. Throughout the narrative this scene stays consistent. The narrator discusses the issues of Jody, her battle with cancer, and her decision for assistance in suicide. The narrator begins her narrative by stating, "My 26-year-old daughter Jody was diagnosed with terminal bone cancer" (see appendix A). This statement introduces the reader to the main issues within the scene--Jody and her terminal cancer. Within the final paragraph of the narrative the narrator states, "It was her [Jody] right as a capable, rational adult to choose her time of death." Within this statement the narrator informs the reader that Jody prematurely ended her life. Also, this statement represents how the narrator continuously discusses the issues of Jody and her battle with cancer throughout the narrative. Throughout the scene, the narrator provides specific examples of things that Jody did to fight her cancer. This includes having operations, chemotherapy, radiation treatments, and being heavily drugged. Overall, the plot and characters within the narrative relate to the scene in such a way that the scene itself would not exist without Jody or her fight with terminal cancer. If Jody Rosen had not been diagnosed with cancer, Patti Rosen would not create the same scene she presents to the reader.

Throughout the scene, the narrator includes detail in how Jody was forced to live life and the things Jody did to fight her cancer. Patti Rosen states, "As the cancer grew, Jody developed tumors under her skin." She adds, "Jody withstood the pain. . . . putting on a brave face for everyone." Additionally, the narrator presents detail in her discussion of the way she felt as the mother of a child with cancer. Patti Rosen states, "I cried, but I finally agreed [to let Jody die with assistance]. I was there when she fell asleep for the last time." She adds, "As Jody died, I crawled into bed with her."

Characters

The main characters within the narrative are the narrator, Patti Rosen, and her daughter, Jody Rosen, who died from terminal bone cancer. The narrator presents the reader with personal information within the opening lines of the narrative. This includes the narrator's name, area of residence, and occupation. This information allows the reader to make a connection with the narrator, in the way of thinking of her as a real person, not just a "faceless name" writing the narrative. While there is no mention of the narrator's physical traits, the reader views Patti Rosen as a flat character, possessing few dominating traits which are highly visible throughout the narrative. These traits include being a caring mother who rejected her daughter's initial request of giving up on life and a supporter of assisted suicide. The reader senses the narrator's hope for some sort of alternative to prolong her daughter's death when she states, "Could there be a new cure? Or a new treatment." Additionally, the reader views the narrator as a caring mother, consoling her ailing daughter. Patti Rosen states, "As Jody died I crawled in bed with her." She adds, "I was able to hold my daughter in my arms as she died in peace." Furthermore, the reader views the narrator as a supporter of assisted suicide. Patti Rosen states, "Did I break the laws of government? Yes." She adds, "Please vote yes on Ballot Measure 16." These statements clearly represent the narrator's feeling towards assisted suicide and its use in her dying daughter's situation.

The second major character, Jody Rosen, is at the center of the scene. Jody's physical traits include the development of tumors under her skin, pain all over her body, and being "bedridden, unable to touch and be touched." The reader views Jody, as a character, in more of a round way, possessing several dominating traits. These traits include living as a victim of cancer, yet trying to be a fighter of the disease, being a caring daughter, and being a person concerned for those around her. The reader is told that Jody was diagnosed with terminal bone cancer in 1986 at the age of 26. As a victim of cancer, Jody initially fought for life after her diagnosis. The narrator informs the reader that Jody

underwent operations and radiation treatments to help fight the cancer. Additionally, Jody went on living knowing that “the remainder of her life would be spent dying. . . . in agonizing pain. . . . without hope.” Jody also possesses the trait of being a caring daughter, as she informs her mother that she is only trying the chemotherapy for her (Patti Rosen). The statement, “Jody withstood the pain and mental anguish as best she could, putting on a brave face for everyone.” signifies Jody’s desire to think of more than just herself, even in her time of pain and suffering.

Narrator

The narrator mediates the story to the audience within this narrative. The reader does not witness the action as it is occurring, but is instead told about the events and characters by the narrator. The narrator presents the narrative in past tense and signifies her presence by the use of “I.” As previously discussed, the narrator appears to be a caring mother and an advocate of assisted suicide. The narrator uses very simplistic wording throughout the narrative, which allows readers with various educational levels to understand all the aspects of the narrative. These aspects include the plot, characters, and various situations endured by Jody Rosen. Simultaneously, the narrator uses descriptive words such as “agonizing pain,” “mental anguish,” and “heavily drugged” to add detail to the story and to keep the reader’s attention. This type of descriptive language adds to the vividness of the story, while allowing the information to remain straightforward and direct. The narrator claims her authority by stating, “[I] work as a medical educator.” The inclusion of this statement presents the narrator as someone not only credible to discuss the situation with her daughter, but also the issue of assisted suicide. Because the scene involves the narrator’s daughter, the reader does not doubt judgments the narrator makes such as “[Jody was] heavily drugged and hated it.” The reader assumes that Patti Rosen was with her daughter throughout the events (from within the narrative). Therefore, the reader does not question her interpretation of situations.

Events

The major events, or kernels, of the narrative include Jody Rosen's diagnosis with terminal bone cancer and the situation that occurred when she used medication to prematurely end her life. The minor events, or satellites, are the various situations and issues Jody dealt with while living with cancer. These events include, yet are not limited to, Jody's use of chemotherapy, radiation, pain medication, and trying to hold on to life.

Temporal Relations

The narrator does not inform the reader of the actual length of time the events occurred within the narrative. The narrator states, "For several months I resisted [Jody's request for assisted suicide]." This statement allows the reader to assume that the events took place over a brief period of time. As previously discussed, the narrator discusses the issues and events within the narrative in past tense.

Causal Relations

The narrator does not establish clear cause and effect relationships within the narrative. Although, the reader assumes that there are some obvious connections among issues. This includes the fact that Jody's pain of living with cancer caused her desire for life-ending medication (the effect). Furthermore, the cause of Jody using medication, as the means of assisted suicide, brought about the obvious effect of her premature death.

Narrative Two

Setting

The narrator, Edythe Steinbock, creates the scene within this narrative. The scene consists of the narrator's discussion of specific events in her husband's life, which relate to his request for assistance in dying. The scene stays consistent throughout the narrative. The narrator's discussion includes the elements of Irv Steinbock, the issues he dealt with

when requesting assistance in dying, and his beliefs on the issue of death with dignity as a law. In the opening paragraphs of the narrative, the narrator is direct in stating that her husband was diagnosed with digestive cancer, wanted to die in a humane way, and requested medication to end his life. The reader does not assume how the cancer patient felt about dying or what he wanted to do with the rest of his life, due to the narrator's straightforward manner in presenting the information relating to these issues. As the scene progresses, the narrator discusses her husband's concerns for requesting assistance in dying. This includes the issues of family and religion. Edythe Steinbock states, "Irv asked our rabbi if in God's eyes his action would be a sin" (see appendix B). She adds, "We told our children. They agreed it was their father's decision. . . ." The concluding aspects of the scene involve Irv Steinbock and his beliefs on death with dignity. The narrator states, "Irv and I talked often about death with dignity and the need to change the law." She adds, "Irv would have been a strong supporter of Measure 16." Such statements reinforce Irv Steinbock's belief on the issue of death with dignity, beyond his own request to use the method. The scene consistently involves the same elements throughout the narrative. Furthermore, a clear progression of the issues involving these elements exists. The plot and characters within the narrative relate directly to the scene. It is these aspects which create the core of the scene.

The narrator provides detail throughout the scene concerning several issues. Among these issues is the discussion of information pertaining specifically to what Irv Steinbock took into consideration when planning the end of his life. The narrator includes details regarding her husband's views on religion, family, location and method of death, and having personal peace with the decision to die prematurely.

Characters

The narrator, Edythe Steinbock, and her husband, Irv Steinbock, who died from digestive cancer, are the main characters within the narrative. The narrator presents the

reader with the statement, "My name is Edythe Steinbock. . . . my husband, Multnomah County Circuit Court Judge Irv Steinbock, was diagnosed with digestive cancer." within the opening paragraph of the narrative. This statement introduces the reader to the main characters within the narrative. While there is no mention of the narrator's physical traits, the reader views Edythe Steinbock as a flat character. The traits of this character include being an advocate for death with dignity and a supportive, caring wife. The reader views the narrator as an advocate of death with dignity. Edythe Steinbock writes, "Irv and I talked often about death with dignity and the need to change the law." The reader assumes that the issue of doctor-assisted suicide was of great importance to both Edythe and Irv Steinbock if the issue was discussed on more than just a few occasions. Additionally, if the narrator states that she felt the law needed to be changed from its current legal status, the reader can assume she was a strong advocate for the issue of death with dignity. In fact, this assumption appears to be confirmed as the narrator states that she is working as a volunteer on the Measure 16 campaign.

In addition to being an advocate of death with dignity, the reader views the narrator as a supportive, caring wife. Within the narrative there is no mention of the narrator's disagreement with her husband's choice to prematurely end his life. Also, the narrator appears to be with her husband throughout his preparation of dying prematurely. This includes helping Irv inform their children of his decision to die prematurely by medication. Furthermore, the narrator states that she has become a volunteer on the Measure 16 campaign because she knows her husband would have also been as strong supporter. The narrator's dedication to the issue of death with dignity because of her husband reinforces the reader's assumption that she was supportive of his request for assisted suicide. If the narrator did not agree with how her husband wanted to end his life, she would not join a cause which would be trying to make the same practice legal. Finally, the reader views the narrator as a caring wife to her late husband. While the narrator not only supported her husband's request to die and eventually joined a cause that

he “would have supported,” she was concerned about the way his final days would be spent. The narrator states, “He [Irv Steinbock] was in control of his final day. He was at peace. For that I thank God.”

The second major character of this narrative is Irv Steinbock, who is the central character of the scene. While there is no mention of Irv Steinbock’s physical traits, the narrator informs the reader that Irv was forced to spend his last days in the hospital. The reader assumes that physically, Irv was probably unable to move freely or function on his own. The narrator presents Irv, as a character, in a round way--possessing several dominant traits. These traits include how he lived life, both personally and with cancer, his desire to end his life in a specific way, and his views on the institutions of government and religion. The narrator informs the reader that “several years ago” (from the time of the narrative’s writing) Irv was diagnosed with cancer. This statement implies that not only has Irv Steinbock initially handled his life with cancer, but that he did not try and end life prematurely when he was first diagnosed. Instead, Irv learned to live with a terminal disease. Additionally, the narrator states that Irv was a conservative judge, which leads the reader to assume that most of Irv’s beliefs in life were along the lines of a conservative nature. Another trait the reader views in Irv Steinbock is that he is a man who took more than just himself into consideration when making important decisions. Irv considered many things when initially requesting assisted suicide. First, Irv considered religion--whether or not it would be a sin in God’s eyes to die prematurely. Next, Irv considered the place and the manner in which he wanted to die--this being at home in a dignified way. The reader knows that Irv Steinbock had specific views on the involvement of religion and government in the lives of dying adults. The narrator states, “We [Irv and herself] both believed with great conviction that government and religious institutions should not inhibit the rights of rational, dying adults who wish to end their suffering.” As a whole, the reader views Irv Steinbock as a round character.

Narrator

The narrator mediates the story to the audience within this narrative. Edythe Steinbock interprets the events of her husband's life--specifically those which surround Irv's choice to die by the use of medication. The narrator presents the narrative in past tense to and she signifies her presence as a narrator by the use of "I" within the story. Additionally, because the narrator refers to her husband by using "he" and "Irv" the reader knows that Irv Steinbock is not the narrator. As previously discussed, the narrator appears to be an advocate of death with dignity, along with being a supportive, caring wife. Throughout the narrative, the narrator uses simplistic words and a straightforward vocabulary, which is easy to understand. This allows the reader to relate to what the narrator is stating and focus on her discussion, instead of stopping to decipher words and phrases. While the story is not told with explicit detail, there is a vivid discussion of issues that the narrator's husband considered when he wanted to prematurely end his life. By focusing on more than one of her husband's concerns, the narrator allows the reader to gain a greater sense of her husband as a person and how he lived. The narrator claims her authority by stating, "My husband. . . ." This informs the reader on the relationship between the characters and makes it unlikely that the reader will question whether or not the narrator is qualified to discuss the events. Furthermore, this establishment of the relationship between the characters makes the narrator credible in making the statement, "Irv would have been a strong supporter of Measure 16. . . . He was in control of his final day. He was in peace."

Events

The major event, or kernel, of this story is Irv Steinbock's decision to die by the use of medication and the various concerns he had before he died. The narrator explains this event to readers by using several minor events, or satellites. These satellites include Irv's concern with religion, family, where he would die, and his final night living.

Additionally, the reader views the event of Irv and Edythe's opinions regarding death with dignity as a satellite.

Temporal Relations

Although the narrator states that Irv Steinbock had been diagnosed with cancer "several years ago" (before the narrative was written), the events within the narrative occur over a brief period of time. While the narrator does not give an exact length of time of the events, the reader assumes that it was not more than a few weeks. As previously discussed, the narrator presents the events and issues within the narrative in past tense.

Causal Relations

The narrator establishes one clear cause and effect relationship within the narrative. The narrator discusses her belief that Irv was able to die in peace knowing that his pain would soon be over. This idea of "being over" relates to Irv's belief that he was coming home from the hospital to die by the use of medication. Hence, Irv Steinbock's peaceful passing occurred because he knew he would soon be coming home from the hospital, to take medication, and prematurely die.

Narrative Three

Setting

The narrator, Laurel Nordlund, creates the scene within this narrative. The scene consists of the narrator's discussion that the quality of life should not be measured by health, but through relationships. The narrator acquires this belief when her husband, Bruce Nordlund, was given a prognosis of two to six months to live, with maybe only two "good" months (according to his doctor). The scene stays consistent throughout the narrative. The narrator first presents her belief of what constitutes the quality of life

within the opening paragraph of the narrative. Laurel Nordlund states, “If there is one lesson I learned through my husband’s dying process, it is that the quality of life should not be measured by health” (see appendix C). As the scene progresses, the narrator continues to discuss the issue of the quality of life as it pertains to her husband’s battle with cancer. She explains that her husband’s prognosis of six months to live was correct, but that the doctor’s warning of only two “good” months was not accurate. The narrator states, “Of course, the ‘good’ the neurologist was referring to was the quality of health. For me, the ‘good’ was measured through the quality of relationships.” As the scene concludes, the narrator explains how her husband’s remaining six months were all “good” months. She states, “Relationships grew with others and with one another. It was an opportunity to be with him, to talk with him and for him to teach us about dying.” The plot and characters within the story are the central elements within the scene. The narrator creates the scene around the central character, her husband, Bruce. The plot consists of the way Bruce lived his last months of life and the narrator’s measurement of his quality of life.

Throughout the scene, the narrator provides detail in the discussion of her husband’s diagnosis with cancer and in her belief of what constitutes the quality of life. The narrator informs the reader that Bruce Nordlund had a tumor 1/3 the size of his brain, that his illness progressed from a simple headache and weakness to complete loss of muscle strength, and that life was very important to him. These details allow the reader to better understand Bruce, as a person. In her discussion of the quality of life, the narrator provides detail relating to the issue of relationships. The narrator states that relationships between her husband and others grew, that Bruce was a key participants in others lives, and that within his relationships, Bruce taught others about the issue of dying. These details reinforce the narrator’s belief that the “quality of life” refers to more than just a person’s health.

Characters

The main characters within the narrative are the narrator, Laurel Nordlund, and her husband, Bruce Nordlund, who died from terminal brain cancer. The narrator does not disclose her own name or any personal information within the narrative itself. The reader knows the narrator's name by the concluding line of the narrative, "Laurel Nordlund." Additionally, there is no mention of the narrator's physical traits within the narrative. The reader views the narrator as a flat character, possessing a few dominating traits. These traits include her belief in the quality of life, along with the emphasis she places on the importance of relationships. As previously discussed, the narrator views the quality of life as more than just a person's health. The narrator states, "When you are given a short amount of time to live, your perception of what constitutes quality in life changes." Subsequently, the narrator's perception of the quality of life concerns the quality of relationships. The issue of relationships and their importance is a dominating trait of the narrator. The narrator makes this a dominating trait through the use of her words and her consistent inclusion of this issue within the story. The reader senses that the issue of relationships is an important aspect in the narrator's life.

The second major character is Bruce Nordlund, who is the central character of the scene. Bruce's physical traits include having a tumor 1/3 the size of his brain and physically progressing from simple weakness and a headache to total and complete loss of muscle strength. The reader views Bruce, as a flat character, possessing a few dominating traits. In fact, through the narrator's presentation of this character, the reader views Bruce as having the dominating trait of teaching others. The narrator states that Bruce taught others about dying and the issue of death had a great impact on others. Laurel Nordlund states, "It [being taught about dying] strengthened us to live on without him."

Narrator

As the narrator, Laurel Nordlund mediates the story to the audience. Through her interpretation of events, the narrator informs the reader on the issues of Bruce Nordlund's cancer, aspects of his last six months of life, and his relationships with others. The narrator discusses events within the narrative in past tense and creates her presence by using "I" within the story. As previously discussed, the narrator appears to value the importance of relationships and has particular beliefs towards what constitutes the quality of life. The narrator's word choice is simple and easy to understand. This type of wording allows readers to gain an easy comprehension of the narrative. The narrator does not use a lot of descriptive words and phrases, which relates to the lack of vividness found throughout the narrative. Although, the reader does gain a sense of vividness in the narrator's discussion of the quality of relationships--pertaining to Bruce Nordlund's last six months of life. The narrator does not appear to be an authority on the issues she discusses, beyond being the wife of a cancer patient--who is the central figure within the events. The narrator interprets and evaluates the events within the story. Laurel Nordlund interprets what she believes "good" refers to in her husband's diagnosis. She states that "the good the neurologist was referring to was the quality of health." Furthermore, the narrator interprets how her husband viewed life. She states, "Even when my husband was very, very ill, his life was very, very vital--to him. . . ." The narrator evaluates the issue of relationships in saying, "Relationships with others and with one another grew. . . . He [Bruce] was a key participant in our life." Additionally, the narrator evaluates the last months of her husband's life by stating, "All six months were good ones. They were perhaps some of the best of our entire life together." Overall, the narrator appears to be reliable in her discussion of issues and events because the central figure is her husband. Therefore, the reader does not question the narrator's statements and interpretations within the narrative.

Events

The major event, or kernel, within the narrative consists of the relationships that Bruce Nordlund built upon within the remaining six months of his life. The issue of relationships is a key aspect of the narrative and the narrator discusses Bruce's interaction with others as a major event. The minor event, or satellite, involves the narrator's opinion of Measure 16--which is briefly touched upon at the conclusion of the narrative. Laurel Nordlund states, "I fear the implications of Ballot Measure 16, for it communicates that the quality of life is measured only by health." Another minor event is the way Bruce Nordlund's life actually ended. The narrator sums up this period of time by simply stating that the doctor's prognosis was correct and that there was a decline in Bruce's illness. The narrator does not provide a lot of details to explain the end of her husband's life.

Temporal Relations

The events within the narrative occur within the last six months of Bruce Nordlund's life. As previously discussed, the narrator discusses events within the narrative in past tense.

Causal Relations

The narrator establishes two clear cause and effect relationships within the narrative. The first relationship concerns Bruce Nordlund's death and the narrator's belief of what constitutes the quality of life. Laurel Nordlund states, "If there is one lesson I learned during my husband's dying process, it is that the quality of life should not be measured by health." Therefore, the cause of Bruce Nordlund's death brought about the effect of Laurel Nordlund's belief concerning what constitutes the quality of life.

The second cause and effect relationship involves the idea of Bruce Nordlund teaching others about death and what this gave to those around him. The narrator states, "It was an opportunity to be with him, to talk to him and for him to teach us about dying."

It strengthened us to live on without him.” Hence, the cause of Bruce Nordlund’s discussion with people about dying, brought about the effect that these same people were strengthened to live on without him.

Narrative Four

Setting

The scene within the narrative consists of the narrator, Corrine Harris, discussing her life with breast cancer. This scene stays consistent, as the narrator discusses specific issues throughout the narrative. The narrator develops the scene by discussing her emotions related to having cancer, the treatment she has used to fight her cancer, and how she feels physically, today (when the narrative was written). The narrator informs the reader of the issue of her cancer within the opening paragraph of the narrative. Corrine Harris states, “Fourteen years ago, I was diagnosed with breast cancer” (see appendix D). The narrator discusses the activity surrounding her cancer. She informs the reader of her assumption that she had successfully battled the disease in the past, until doctors detected it for a second time. As the scene progresses, the narrator discusses her emotions concerning the cancer. She states, “I was in enormous pain. I could hardly move. I cried and cried.” In the conclusion of the scene, the narrator informs the reader of her choice of treatment and her feelings concerning the option. The narrator states, “Hospice was sent in. . . . Today, with aggressive hospice intervention, I’m comfortable.” She adds, “I enjoy living now more than ever. I can’t wait to wake up in the morning.” The scene consistently involves the narrator as the main character. Additionally, the plot within the scene consists of the narrator’s life with cancer--specifically her emotions and treatment. This exact scene would not exist without the elements of Corrine Harris and her discussion of life with cancer.

The narrator provides detail for the issues concerning her emotions and pain in living with cancer and her choice of hospice to control her disease. The narrator informs the reader of her mental and physical state due to cancer. Harris states, "I was devastated! I felt I was in a dark, scary, downward spiral, out of control." She adds, "I couldn't get to the bathroom; that was degrading. I didn't have the knowledge or training to even identify the tools to help me cope with my new situation." Furthermore, the narrator provides detail for the issue of her choice of hospice to control her pain. The narrator informs the reader as to why she chose hospice, what the hospice team said they would do for her, and how hospice has helped her live. The narrator states, "Because Measure 16 was not in effect, I could not obtain a prescription for death from my doctor." This accounts for why the narrator chose the hospice option. Additionally, the reader knows what the narrator expects from the hospice option as she states, "The hospice team made a commitment to me: to keep my pain under control and provide me with the support and equipment that would allow me to have the best quality of life for the time I have remaining." Finally, the narrator provides detail in how she is now living because of her decision to use hospice care. The narrator states that she is comfortable, anticipates each new day, and enjoys living.

Characters

The main character within the narrative is the narrator, Corrine Harris, who is living with breast cancer. The reader is introduced to this character within the opening lines of the narrative. The physical traits of this character include having the disease of breast cancer which made it nearly impossible for her to move because of the enormous pain of the disease. The reader views the narrator as a round character, possessing a variety of dominating traits. These traits include being a fighter for life, someone who seeks to improve the quality of how she lives with a disease, and a person who appreciates life. One senses that the narrator is a fighter for life because Corrine Harris informs the

reader that she was first diagnosed with cancer fourteen years ago. She states, "I fought the battle and believed I had won. . . ." Furthermore, after Corrine Harris was diagnosed with incurable cancer she did not give up, but looked for options to improve her life. This illustrates another trait the narrator possesses. Instead of living life as if it were going to end because her breast cancer was found to be incurable, Corrine Harris turned to doctors for help and for options in living. The suggestion of hospice care was given to Corrine and she continued life with this intervention. The reader also views the narrator as possessing the trait of appreciating life. After using hospice intervention to control her pain, Corrine Harris represents a person who appreciates living. She informs the reader that she anticipates waking up and the start of each new day. The narrator states, "I don't know how I'll talk when I come close to death and get sick again but I know the added days were worth it." She adds, "I've heard people who have nearly died talk about how much more they appreciate living. It's so true."

Narrator

As the narrator, Corrine Harris mediates the story to the audience. As previously discussed, the narrator informs readers about her disease, how she felt physically and emotionally, and what option she used to live comfortably with incurable cancer. The narrator creates her presence within the story by using "I" to represent that she is narrating the story. The narrator does not need to interpret the events within the narrative, as she was personally involved with the issues and situations she explains to readers. As previously discussed, the narrator appears to be a person who fights for life and appreciates living. She also appears to consider life in specific terms. The reader assumes this about the narrator as she states, "Life is about quality, not quantity--making every minute count." The narrator uses a very straightforward, simplistic vocabulary which is easy for the reader to understand. Additionally, this type of wording allows the reader to relate to the narrator, putting him or herself in the narrator's place to try and understand

what she is enduring. The story is vivid in terms of the narrator's discussion of her feelings towards being diagnosed with cancer for a second time, her discussion of the emotions and pain she endured, and her choice to use hospice intervention. Because the narrator is the person who was directly involved with the issues within the narrative, she is obviously reliable to discuss the events. Overall, the narrator's discussion of information ranges from events in the past to potential events in the future.

Events

The major events, or kernels, of the story include Corrine Harris' diagnosis with cancer for the second time, her request for hospice intervention, and the way she feels now that she has the help of hospice care. Because the narrator discusses each event thoroughly, the reader views each as being a kernel. There are two minor events, or satellites, within the narrative. The first satellite concerns the narrator's discussion of her original diagnosis with cancer. The narrator informs the reader that she was diagnosed with breast cancer several years ago and that she had "battled" the disease. Additionally, Another satellite consists of the narrator's involvement with others who have nearly died and talk about how much they appreciate living. With each of these events, the reader finds a lack of information. This constitutes the reader's perception of these events as satellites, rather than kernels.

Temporal Relations

Although the narrator states that she was first diagnosed with cancer fourteen years before the narrative was written, the specific events within the narrative appear to occur over a brief period of time. The reader makes this assumption, as the narrator does not offer a specific frame of time in which the events took place. The narrator presents the events within the narrative in past tense.

Causal Relations

The narrator establishes one clear cause and effect relationship within the narrative. Corrine Harris states, “Because Measure 16 was not in effect, I could not obtain a prescription for death.” Therefore, the cause of Measure 16 not being considered a constitutional law brought the narrator’s inability to obtain a doctor’s prescription for death (the effect).

Narrative Five

Setting

The narrator, Dorothy Anker, creates the scene within the narrative. The scene consists of the narrator’s frustration over lawmakers trying to repeal the decision Oregon voters made involving the issue of death with dignity. While the scene stays consistent throughout the narrative, the narrator develops it broadly to include her personal feelings towards death and dying with dignity. The narrator develops the scene by opening the narrative with comments concerning the issues of the government, people’s choices, and voting. The narrator states, “Is it any wonder that the public has become cynical about voting, no longer supports a government. . . . abhors politicians’ disregard for people’s choices” (see appendix E). This opening presents readers with the narrator’s feelings on these specific issues, while also introducing the reader to the main focus of the scene. This focus concerns Oregonians passage of a law concerning death with dignity, only to find lawmakers trying to reject their decision. The narrator states, “The people of Oregon have gone to the polls and made an important decision about. . . the choice to have help in dying.” She continues, “By what right do you [legislators] ignore that vote and take it upon yourselves to rescind that decision?” The narrator concludes the scene by including personal feelings towards death and dying with dignity. The inclusion of this information allows readers to better understand the narrator as a person. Dorothy Anker states, “I

expect to die from cancer. I do not fear death nor even the pain involved. I have lived a productive life. Let me die with dignity in my own time.” The development of the scene specifically involves the character, Dorothy Anker, and her feelings towards death and dying with dignity. Additionally, the plot within the scene is the issue of death with dignity voted on and passed by Oregonians and lawmakers considering to reject that vote.

The narrator provides detail within specific areas of the scene. The first area involves the narrator’s discussion of voters passing laws and lawmakers rejecting their decisions. The narrator also provides readers with a detailed analogy, which helps clarify her belief on the issue of lawmakers rejecting Oregonians decision on death with dignity. Dorothy Anker states, “It is as if 68 Oregonians (the number of legislators) took it upon themselves to oust a legislator (whom they did not happen to like) who had been elected to office.” There is also detail found in the narrator’s discussion of her own death and dying with dignity. Dorothy Anker informs the reader of her fears, her concerns for others around her, how she feels about the life she lived, and her view on death with dignity. As previously discussed, this detailed information allows the reader to gain a better understanding of Dorothy Anker as a person.

Characters

The main characters within the narrative are the narrator, Dorothy Anker, and the persons (the public and legislature) whom she presents very specifically to the reader. The narrator informs the reader of her age and the way she assumes her life will end. She states, “I am 68 years old. I expect to die from cancer.” It is unclear to the reader why the narrator includes this specific information. Furthermore, the reader does not know if the narrator expects to die from cancer because of choices in her lifestyle or due to something hereditary. The reader assumes that this character has a high level of intelligence, as the narrator includes her status of “PhD” at the end of the narrative. While there is no mention of this character’s physical traits, the reader views the narrator

as being a round character, possessing a variety of dominating traits. These traits include having a particular viewpoint of government and politicians, maintaining a clear perception of family, and feeling strongly on issues which affect an individual's rights. The reader senses that the narrator views government and politicians very particularly by her opening comments within the narrative. Additionally, the narrator states, "The courts are currently deciding the legality of doctor assisted suicide; surely the legislature is not in a position to make such a decision." The narrator makes this comment as if to say that the members of the Legislature should not put themselves at a level even remotely close to the court's position. Furthermore, the reader senses the narrator's clear perception of family when she discusses her fear of living with a disease and not having the option of assisted suicide. The narrator states, "I am terrified of the debilitating nature of the disease. . . . and the terrible pain I will cause my family who love me and will suffer for me." Finally, the reader perceives Dorothy Anker as feeling strongly towards issues which effects an individual's rights. She states, "This [death with dignity] issue is NOT like. . . . other decisions which effect many lives or that can do harm to large numbers of people. This is an issue that effects ONE person. . . [emphasis added by the author]. "

The second major character consists of the persons (public and legislature) the narrator presents very specifically to the reader. The narrator discusses each of these characters in a very specific manner. This forces the reader to view each character as only possessing a few dominating traits. The narrator presents the public as a character who is very misanthropic about voting yet who has gone to the polls to vote on death with dignity because they "consider it a requisite for the quality of life." The narrator presents the government as a character who ignores the public's voice and shows disregard for people's choices. The narrator does not thoroughly develop each character, so the reader is given a one-sided view.

Narrator

The central character, Dorothy Anker, mediates the story to the audience. She creates her presence as a narrator through the use of “I” within the narrative. Furthermore, the narrator’s discussion of her personal beliefs towards death and dying with dignity (she consistently uses “I”) helps reinforce her role within the story. As previously discussed, the narrator is a highly educated person. This is obvious to the reader both by her title of “PhD” listed at the end of the narrative and because of the narrator’s word choices within the narrative. The narrator chooses to use such words as “cynical,” “abhors,” and “demeaning,” to explain and discuss her opinion on various issues. As previously discussed, the narrator appears to be the type of person who values an individual’s right concerning life and death and the well being of family. Additionally, the reader views the narrator as a person against governmental interference in the laws voters pass. While the narrator presents various opinions and beliefs on issues, her attitude appears to shift depending on the subject matter she discusses. The reader senses that the narrator is both reliable and credible to share her opinions on the various issues, because of her education and the sophisticated manner in which she presents the information. The narrator varies how vividly she presents the narrative. At times the narrator is more specific in detail--such as when discussing the Oregon Death with Dignity measure Oregonians passed and when explaining her personal beliefs on the issue. Although, the narrator is also vague with details concerning some issues--including the reason why she expects to die from cancer. Overall, the narrator interprets and evaluates most of the issues within the narrative. At times the narrator does describe situations. This includes her fears towards death and potentially dying from cancer.

Events

The major event, or kernel, within the narrative consists of Dorothy Anker’s discussion of Oregonians passage of Measure 16 and the repeal effort made by members

of the Oregon Legislature. The minor event, or satellite, involves the narrator's personal belief in how she will die from cancer.

Temporal Relations

The narrator does not inform the reader of the actual length of time events occur within the narrative. The reader assumes that the events span over at least a few years because the narrator makes reference to Measure 47, which Oregonians voted on prior to the Death with Dignity measure. The narrator discusses previous events at the voting booth in past tense. Additionally, the narrator describes in present tense what the legislature may try to do with issues voted on by Oregonians.

Causal Relations

The narrator establishes one clear cause and effect relationship within the narrative. Dorothy Anker states, "The people of Oregon have gone to the polls and have made an important decision about what they consider a requisite for the quality of life--the choice to have help in dying." Therefore, the desire of voters to have help in dying caused Oregonians to visit the voting booth in order to make an important decision concerning their quality of life (the effect).

Narrative Six

Setting

Marian Cline, a Community Health Nurse and narrator of the story, creates the scene within the narrative. The scene consists of her discussion of several instances she has witnessed involving persons who had "the peace and joy of dying in the Hospice setting" or who died at "home with family and nurses controlling the pain and other bodily functions." This scene stays consistent throughout the narrative, as the narrator discusses

one instance after another, which creates the core of the narrative. Before the scene develops into Marian Cline's discussion of these various instances, the narrator informs the reader of her beliefs regarding assisted suicide. She remarks that the "Assisted Suicide Bill" needs to be rethought by the public. The reader assumes that the narrator's opinion exists in part to the fact that "when I [Marian Cline] hear discussion about Assisted suicide, I [Marian Cline] hear only a lot of fears" (see appendix F). Prior to the narrator's personal testimony of instances involving dying patients, she informs readers of her credentials as a "retired RN with twenty years experience." The reader assumes that the narrator includes this information as a way of saying, "I am credible to discuss the issues of assisted suicide and those dying patients who lived comfortably without its use." The plot and characters within the story create the scene. The characters consist of Marian Cline and the dying patients within the various instances. The plot consists of the narrator's witnessing of various instances involving dying patients. If either the narrator or the instances involving the dying patients did not occur within the story, the reader would view a completely different scene. Thus, there would exist an entirely different narrative.

The narrator provides minor detail and development within her discussion of each instance involving a dying patient. Altogether, there are five instances the narrator presents to the reader. Each instance consists of the concise development of the situation. This includes the location (cancer ward, person's home, and so forth) of the individual, how the person lived his or her final hours of life, and the way the person's life ended. The narrator includes both her husband and son as characters within the scene.

Characters

The main characters within the narrative are the narrator, Marian Cline, and each of the persons she presents as dying from cancer or other diseases. While there is no mention of the Marian Cline's physical traits, the reader views her as being as a flat

character, possessing a few dominating traits. These traits include strong views concerning assisted suicide and specific beliefs pertaining to the act of dying. The reader views the narrator as having strong views towards assisted suicide. As previously discussed, the narrator states that the public needs to rethink the passage of the “Assisted Suicide Bill”. The narrator informs the reader that she usually hears a lot of discussion about fear when someone mentions the issue of assisted suicide. Marian Cline states, “In reality this fear (of poor medical treatment, being a burden to the family, and so forth) is most likely untrue.” The narrator discusses the instances of her husband and son who each died from specific diseases. Although she does not comment on the issue of assisted suicide within their situations, the narrator does state that she and her family would not want to have cut their (husband and son) lives short. Furthermore, the narrator appears to possess certain beliefs pertaining to the act of dying. The reader is told that people should not be urged to kill themselves as “dying is part of living”. Additionally, the narrator states, “Lets help them [people] to learn to Live Until You Die [emphasis added by the author].”

The second major character within the narrative relates to the dying patients that Marian Cline presents to the reader. Since the narrator does not thoroughly discuss each patient, it is hard for the reader to view each person as a fully developed main character. The narrator does not inform the reader of each person’s name and their physical traits vary in description. For instance, the narrator discusses one patient as “walking the halls of the cancer ward, getting weaker because cancer had closed the tube to her stomach.” The narrator states that another patient, her late husband, possessed a lack of oxygen because of emphysema. Furthermore, the narrator’s son “became progressively paralyzed” because of a brain tumor. Overall, the narrator provides a minuet amount of information, which causes the reader to view each person as a flat character, possessing a few dominating traits. These traits include the importance of religion and family when the time of death is near. In relation to religion, the narrator discusses one patient as having

her minister read scriptures until she took her last breath, while another patient talked of “The Angel of Death”. The reader senses the importance of family for some of the dying patients, as the narrator explains that one person “died at home with his children at his side” and another patient “sat in her room with her family and shared the secrets of her favorite recipes with her daughters.”

Narrator

As the narrator, Marian Cline mediates the story to the audience by discussing events in past tense. The reader views the narrator’s presence by her use of “I” within the narrative. Additionally, the narrator uses “we” when referring to situations involving both a patient and herself. This word choice helps to reinforce Marian Cline’s role as the narrator. The reader assumes that the narrator is the type of person who is dedicated to her profession and to those persons not able to live life unassisted. This assumption is based on the narrator’s statement that she has 20 years experience as a “Community Health Nurse” working in nursing homes. Additionally, this statement establishes the narrator as an authority, making her reliable to interpret the different instances involving dying patients. The narrator appears to value life as she states, “Let’s not urge people to kill themselves. Let’s help them learn to Live Until You Die.” Furthermore, she appears to help comfort patients until their passing. The reader senses this about the narrator because she discusses her interaction with patients, both verbally and nonverbally, into their final hours. The narrator uses a straightforward, comprehensible vocabulary throughout the narrative, which the reader easily grasps. The narrator presents the narrative vividly in terms of providing more than just one or two instances involving persons who had “the peace and joy of dying in the Hospice setting” or who died at “home with family and nurses controlling the pain and other bodily functions.” Overall, the narrator appears to have a positive attitude throughout the narrative. This judgment is

based on the narrator's presentation of information, along with her word choices which include "peace," "joy," and "celebrate life."

Events

The major events, or kernels, of the story involve the narrator's witnessing of instances involving dying patients over the 20 years she has been a Community Health Nurse. The minor event, or satellite, consists of the actual passage of the Assisted Suicide Bill. The narrator does not offer any sort of discussion within the narrative relating to this event.

Temporal Relations

The events from within the narrative occur sometime within the twenty years that the narrator resided as a Community Health Nurse. The narrator does not offer specific dates for each instance she discusses. As previously discussed, the narrator presents the events within the narrative in past tense.

Causal Relations

The narrator does not establish clear cause and effect relationships within the narrative.

Narrative Seven

Setting

William Comer, narrator of the story, creates the scene within the narrative. The scene consists of the narrator's discussion that Measure 16 should be implemented the way it was both "written and approved by a majority of Oregonians." This scene stays consistent throughout the narrative. The narrator begins developing the scene by informing the reader of his credentials. William Comer states numerous occupations, both

past and present, which he has held. In addition, he informs the reader of his involvement with different committees. The reader assumes that the narrator provides this information within the opening paragraph, before stating his beliefs concerning Measure 16, as a way of establishing his credibility to discuss the issues within the narrative. The narrator ends the paragraph with a statement relating specifically to the issue he is focusing on with the narrative--Measure 16. He says, "I also serve on the Pharmacist State-wide Task Force on Measure 16" (see appendix G). As the scene develops, the narrator justifies his belief that Measure 16 should be implemented as a law. This justification occurs through the narrator's discussion of the "today's technology" in medicine and the "development of pain and symptom management." The narrator states, "We can not keep everyone pain and symptom free all the time. People want to have control and the right to make their own end-of-life decisions." As the scene concludes, the narrator briefly discusses issues relating to Measure 16. This includes The Catholic Bishop's Conference, United States Supreme Court deciding on the constitutionality of the issue of death with dignity, and safeguards within Oregon's Death with Dignity Law. Within the discussion of these issues, the narrator continues to mention the main issues behind his writing of the narrative--this being Measure 16 and its implementation as law.

The narrator provides great detail and development throughout the scene. As previously discussed, the narrator informs the reader of his credentials, which include various occupations and leadership roles. Overall, the narrator provides the reader with extreme detail concerning the his "28 years of hospital, home health, hospice and academic experience." Additionally, the narrator provides detail in his discussion of the "today's technology" and "pain and symptom management"; along with the safeguards found within Measure 16. The narrator thoroughly develops the scene within the narrative. He explains his viewpoints concerning the implementation of Measure 16 and his feelings and beliefs regarding the issues surrounding the measure. The reader does not make

assumptions concerning how the narrator feels or thinks because he is straightforward and direct with his opinions and beliefs.

The plot and characters of the story relate directly to the scene. If the narrator (main character) was not involved within the story, by discussing his belief that Measure 16 should be implemented (this being the plot), the reader would not view the existing scene. Additionally, the elements of character and plot are directly related to the detail and development of the story. This occurs as the narrator provides detail as a means of developing the plot.

Characters

Although the narrator mentions the characters of health care providers, Oregonians, and the United States Supreme Court within the narrative, the main character is William Comer. The narrator does not mention his name to the reader within the story, yet it appears as a signature at the end of the narrative. Additionally, the narrator does not inform the reader of his physical traits. The reader assumes that William Comer possesses the physical trait of being an active person. This assumption is based on his plethora of jobs, including that of being a “retired Colonel from the US Army Medical Service Corp.” The reader views William Comer as a round character, possessing a variety of dominating traits. These traits include his concern for ill patients, helping to further the education of others, and acting as an authority on the issue of death with dignity. The reader views this character as having a concern for ill patients because William Comer discusses the issues of pain and symptom management, compassionate care, and the right for persons to make their own end-of-life decisions. Furthermore, the reader assumes that William Comer has a passion for helping others. He states, “I have personally provided pharmaceutical care for over 1000 people living with terminal illnesses.” The reader views this character as maintaining the desire to help further the education of others. The reader senses this about William Comer, as he informs the reader that he is on the faculty of the Oregon State

University School of Pharmacy. Additionally, he discusses his work with the Oregon Board of Health and Board of Pharmacy in developing language for Measure 16 “which would help pharmacists in a variety of ways.” Finally, the reader views this character as an authority on the issue of death with dignity. In addition to the experience William Comer has with working on committees involved with the Oregon Death with Dignity Law, he appears to be knowledgeable on the law itself. The reader senses this about the character, as William Comer discusses the “many appropriate safeguards” contained within the Measure. This information helps the reader better understand Measure 16, while also establishing William Comer as an authority on the measure.

Narrator

As the narrator, William Comer mediates the story to the reader. The narrator informs the reader of various issues including his credentials, his belief that Measure 16 should be implemented as passed by Oregonians, and his views on other issues related to Oregon’s Death with Dignity Law. The narrator discusses issues within the narrative in past tense and he creates his presence within the story by the use of “I.” As previously discussed, the narrator appears to be a confident, intelligent, and credible person. The reader draws these inferences about the narrator after reading a somewhat exhausted list of credentials he presents in the opening of the narrative. Additionally, William Comer’s discussion of Measure 16 and what he believes is best for the citizens of Oregon creates the characteristics readers associate with him as a character. The narrator uses a basic vocabulary, which is clear and concise. The reader does not question the definitions of words or phrases, which allows him or her to focus on the issues within the narrative. The narrator’s attitude on the issues within his narrative is clear to the reader. William Comer believes that Measure 16 needs to be implemented as law. He also believes that actions taken by the Catholic Bishop’s Conference, two weeks after Measure 16 was passed, are suspicious and questionable. Furthermore, the reader views the narrator as being

concerned and supportive towards people's ability to "have control to end their life peacefully with dignity." The narrator establishes himself as a reliable source of information because of his credentials and his clear presentation of ideas and facts.

Events

The major events, or kernels, within the narrative include the narrator's discussion of his credentials, the reasons he feels Measure 16 should be implemented as passed by Oregonians, and his discussion of the safeguards within Measure 16. The minor events, or satellites, include the Catholic Bishop's Conference which took place after the passage of Measure 16 and the United States Supreme Court hearing on the issue of death with dignity. The reader considers these events to be "satellites" because the narrator does not offer a thorough discussion of each issue, as he does with the major events.

Temporal Relations

The narrator does not present the reader with a specific frame of time in which the events occur within the narrative. The reader assumes most events involving Measure 16 occur within a brief period of time. The narrator does inform the reader of the length of time that occurs while he has been involved with his various occupations. William Comer states, "I am a pharmacist with over 28 years of hospital, home health, hospice, and academic experience."

Causal Relations

The narrator establishes one clear cause and effect relationship. William Comer states, "The technology of today has been keeping people alive to the extent that it has outstripped our ability to adequately assure their comfort and deliver compassionate care." Therefore, the cause of using technology to keep people alive has brought the effect of not adequately assuring people's comfort and the ability to deliver compassionate care.

Narrative Eight

Setting

The narrator, Penny Schlueter, creates the scene within the narrative. The scene consists of the narrator's discussion of her frustration with members of the Oregon Legislature debating whether to "repeal or referral or delay" the implementation of Measure 16 as passed by voters. This scene stays consistent throughout the narrative. The narrator presents the reader with her views towards Measure 16 and towards the legislature's potential involvement with repealing the measure. Before the scene begins to develop, the narrator provides the reader with insight on her disease and feelings towards the passage of Measure 16. She states, "For four years, I have been fighting ovarian cancer. I was heartened in 1994 when Oregon voters passed Measure 16" (see appendix H). As the scene begins to develop, the narrator discusses the "legal maneuvering by opponents of Measure 16" and the way the "legislature is debating a law to send back to voters." The narrator relates her personal situation with cancer to the issue of the legislature's grappling of Measure 16. She states, "For me, another year of delay or repeal of Measure 16 may force me to live my final days in agony." The narrator presents the reader with evidence of her involvement with the legislative committee who is responsible for reviewing the death with dignity issue. Penny Schlueter states, "I have attended hearings and I have testified twice." As the scene concludes, the narrator addresses the arguments presented by opponents of the measure. These arguments include the risks of assisted suicide and the lack of safeguards within the measure. She states, "If a few more safeguards are all it takes to convince the Legislature to leave Measure 16 alone, I support that effort. It's wrong for the legislature to try and undo your votes."

Throughout the development of the scene, the narrator provides detail in the issues she discusses. This detail allows the reader to understand Penny Schlueter's involvement within the possible repeal of Measure 16 and her feelings towards the issue of death with

dignity. As the main character within the scene, Penny Schlueter is responsible for creating the plot of the story. This plot consists of her frustration with the possible repeal of the Oregon Death with Dignity Law. The removal of either the character or plot from the scene would change the narrative as it now exists.

Characters

The main characters within the narrative are Penny Schlueter and the Oregon Legislature. There is no mention of the narrator's name, Penny Schlueter, within the story. The reader knows her name simply because it is listed as the author of the narrative. Additionally, there is no mention of this character's physical traits, although the reader assumes Penny Schlueter is not very healthy. The reader bases this assumption on the narrator's statement concerning the possibility that she may live her final days in agony if Measure 16 is delayed for another year. The reader views Penny Schlueter as a round character, possessing a variety of dominating traits. These traits include valuing personal choice, disagreeing with those who go against the voice of voters, and taking other people into consideration--in terms of the passage of Measure 16. The reader senses that the narrator is a person who values personal choice. Penny Schlueter discusses how "the choices of medical treatments near the end of life are very personal choices" and that she felt comfort knowing she had a choice with the passage of Measure 16. Additionally, the reader views this character as someone who disagrees with those who go against the voice of voters. The narrator comments on the fact that while the legal maneuvering of opponents of the measure is bad enough, some legislators think the voters of Oregon did not know what they were doing when they passed Measure 16. Penny Schlueter adds, "It's wrong for the Legislature to undo your votes. It's worse for them to try and control my death." Finally, the reader views this character as being concerned about others in regards to the repeal effort of lawmakers. The narrator discusses the betrayal she feels "for the 600,00 people who voted yes on death with dignity" and for "all Oregon voters

whose votes on initiatives are ignored.” Furthermore, Penny Schlueter presents her feelings towards the issue of doctors who will have to keep private the practice of helping others die if the measure is not passed. She states, “That puts compassionate and caring doctors. . . . at risk of legal investigation and loss of license to practice medicine.”

The Oregon Legislature is the second major character within the narrative. The narrator informs the reader of her beliefs towards the Oregon Legislature, which creates a one-sided view of this character. This, in turn, forces the reader to view the Oregon Legislature as a flat character, possessing few dominating traits. The Oregon Legislature’s dominating trait is the ability to interfere with Oregonians passage of Measure 16.

Narrator

The narrator, Penny Schlueter, mediates the narrative to the reader. The narrator creates her presence by using both “I” and “me” to signify who is presenting the narrative. The narrator discusses events and situations in past tense, while the narrative itself ranges into the past and future. The narrator refers to the past in her discussion of the passage of Measure 16 and discusses the future and whether or not the Oregon Legislature will undo what Oregonians voted as law. As previously discussed, the narrator appears to be the type of person who values personal choice and disagrees with the government’s involvement with issues passed by voters. While the narrator appears to worry about her future and whether she will have the option of assisted suicide, she appears to be a fighter for life. The reader assumes this about the narrator when she states, “For four years, I have been fighting ovarian cancer.” Finally, the narrator appears to have a passion for Measure 16 and holds the belief that the law is a necessity, helping to legalize “an option many want.” Throughout the narrative, the narrator uses a basic vocabulary, which is easy for the reader to follow and understand. This type of vocabulary does not take away from the story’s vividness, as the narrator provides detail in her discussion of her involvement

with Measure 16, the arguments made by opponents, and potential actions of the Oregon Legislature. The narrator states her authority for discussing the issues within the narrative. She accomplishes this by informing the reader that she is a cancer patient inherently interested in Measure 16 as she has been involved with hearings on the potential repeal of the measure. The narrator's authority gives her reliability in the reader's eyes. The reader does not question the narrator's comments and concerns, as she has been involved with the issues she discusses.

Events

The major events, or kernels, of the narrative consists of the Legislature's activity surrounding Measure 16, along with Measure 16 opponents creating arguments against the measure. The minor events, or satellites, include the potential situations involving doctors who may try and hide their practice of helping patients end their lives and the actual passage of Measure 16 by Oregonians in 1994.

Temporal Relations

The reader is not given a frame of time in which the events occur within the narrative. The reader assumes that the events occur within a brief period of time, as the narrative mainly involves issues surrounding the passage of Measure 16. As previously discussed, the narrator discusses issues within the narrative in past tense.

Causal Relations

The narrator establishes one clear cause and effect relationship within the narrative. Penny Schlueter states, "For me, another year of delay or repeal of Measure 16 may force me to live my final days in agony. Instead of enjoying what is left of my life, I will be forced to worry about the pain, the suffering, and the loss of control I may face in my final weeks." Hence, the cause of delaying or repealing Measure 16 will make Penny

Schlueter worry about possible pain, suffering, and loss of control in her final weeks of living (the effect).

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Chapter Four:

Narrative Discourse and Measure 16--Oregon's Death With Dignity Act

The purpose of this chapter is to interpret and present the findings derived from the critical examination of Measure 16 related discourse in chapter three. Additionally, I will draw several conclusions from my narrative criticism of Measure 16 and the issue of doctor-assisted suicide. Finally, I will offer implications for future study involving the issues of narration and public policy.

Interpretation of Primary Sources

In her discussion on narrative criticism, Sonja K. Foss (1996) argues that most narratives contain some sort of a sequence involving two or more events. Foss states, "In many narratives, the sequences are temporally organized, with the order of events moving chronologically through time" (400). In the narratives from the 1994 Oregon Voters Pamphlet, the organization of events demonstrate consistency with Foss' claim. This organizational pattern plays a significant role in the narrator's strategy to persuade voters to his or her view on Measure 16.

Several similarities exist in the narratives favoring the passage of Measure 16. The narrators present a specific scene involving characters who pertain to their individual discussion and each narrator uses a similar strategy to persuade the reader that assisted suicide should be legal. Overall, the narrators focus their discussion on three key areas. First, the narrators discuss the person who lived with cancer. Second, the narrators present different issues the cancer patient dealt with concerning their disease. Third, the narrators explain the cancer patient's request for assisted suicide.

In each pro-Measure 16 narrative, the narrator chooses a similar "starting point." This consists of the narrator's introduction of her role within the story and the identity of the cancer patient she will be discussing. Statements such as "my name is. . . ." and "my

daughter. . . .” or “my husband. . . .” informs the reader of this information. Once the narrator makes these introductions, she begins discussing events pertaining to the cancer patient’s individual situation and his or her request for assistance in dying. The narrator presents these events chronologically within the narrative and consistently offers a biased view about how the cancer patient lives his or her life. The information she selects supports her one-sided view. This strategy helps emphasize the importance of assisted suicide, as the reader is led to think that living with cancer makes for a dark, depressive, and miserable life. The reader begins to think that if assisted suicide were available, these cancer patients would not feel forced to continue living such a life.

As a way of reinforcing this pro-Measure 16 belief within the reader, the narrator presents her discussion of events in the cancer patient’s life in chronological order. This structure leads the reader to feel as if he or she is witnessing the events as they happen. The reader invests emotions in each event and begins to identify with the characters and their hardships. Because the narrator does not arbitrarily discuss events, the reader is able to maintain a mental picture of the scene as it unfolds. Simultaneously, the reader begins to understand the narrator’s reasoning behind supporting assisted suicide, therefore he or she also wants to support the passage of Measure 16. If the narrator were to abandon this chronological sequencing of events, the reader would react differently to the narrative. The reader would simply view each event as a random situation from within the narrator’s life and, consequently, invest fewer emotions in the narrative. Inevitably, the reader may not be as willing to support the narrator’s stance on assisted suicide and, thus, the passage of Measure 16.

The narrators who favor the passage of Measure 16 use rhetoric very similarly. By presenting the reader with a one-sided view of the cancer patient’s life and organizing events so that the reader’s emotions are invested, the narrators produce an effective strategy. If successful, the reader will support the availability of assisted suicide. This, in turn, encourages him or her to vote “yes” on Measure 16 at the voting booth.

In analyzing the data derived from the narratives written against Measure 16, similarities also exist within the narrators discussion and presentation of information.

Although the narrators discuss individual scenes and specific characters within their narrative, they each attempt to persuade the reader that assisted suicide should not be made a legal practice in Oregon. In persuading the reader of this belief, the narrators use a very specific approach within their narrative. This approach involves presenting the reader with a realistic look at the cancer patient's life--discussing both positive and negative events which occur while the person lives with a terminal illness. The narrators take this approach to show the reader that although a cancer patient's life may not be completely good when living with his or her illness, it is not completely horrific either. Additionally, the narrators focus on one main theme within their discussion. This theme concerns a positive experience the cancer patient had while living with his or her disease. The narrators rely on this aspect of their discussion as a way of defending their belief that a dying person should not simply opt for assisted suicide.

The anti-Measure 16 narrators present the reader with what appears to be a realistic look at the cancer patient's life. The narrators do not attempt to bias their discussion by only including situations and events which would depict life with cancer in a specific manner. Instead, the narrators use a chronological sequence to discuss both positive and negative events. The inclusion of this information, within the narrator's style of presentation, allows the reader to mentally picture a logical scene as it unfolds. The scene allows the reader to understand what life is like for a person living with a terminal illness. Thus, the reader associates with the character as a real person, not just a character the narrator is discussing.

Additionally, the narrators focus on a main theme within their discussion. This theme consists of a positive experience the cancer patient had while living with his or her illness. The themes include the ability to strengthen personal relationships with others and to utilize options (such as hospice) to deal with the pain of a terminal illness. By including

this type of element within their discussion, the narrators accomplish two important things. First, they are able to reiterate the idea that life with cancer means more than just living and dealing with negative events and situations. Second, the narrators inform the reader that if Measure 16 were enacted, and the cancer patients automatically felt as if they needed to use it, then they would miss the opportunity to experience positive situations.

There are several consistencies found in the narratives urging voters not to support Measure 16. The narrators are very specific with the information they include for discussion and each focuses on a positive experience in the cancer patient's life. Because the reader has been persuaded that there is more to a cancer patient's life than just a horrible existence, he or she questions whether assisted suicide should be an option for the dying. This, in turn, encourages the reader to debate whether to vote "yes" on Measure 16 at the voting booth.

Interpretation of Secondary Sources

As with the primary source narratives, the discourse in the secondary source category involves the narrator's discussion of opinions and beliefs towards Measure 16 and the issue of doctor-assisted suicide in Oregon. Yet, while the target audience for the primary sources is Oregon voters, a shift occurs in the audience for the secondary sources. Along with the Oregon voters, members of the Oregon Legislature compose the target audience for these sources. This shift in audience affects the narrator's discussion, specifically in the information he or she discusses.

Foss (1996) states that in some narratives, the sequences are constructed through other than temporal means. These include a character, theme, or quality (400). The narrators who aim their discourse at both Oregon voters and government officials construct their sequence of events through a theme. This theme concerns whether or not the Oregon Legislature should repeal the passage of Measure 16.

There are several similarities in the discourse focusing on the Oregon Legislature's potential involvement in the repeal of Measure 16 (the repeal was only possible at the time the narratives were written). These similarities include the narrator's clear presentation of a personal agenda and the use of artistic proofs, ethos and pathos, as a means of persuasion.

Within each narrative, the narrator clearly states his or her opinion on whether the Oregon Legislature should become involved in the repeal of Measure 16. The narrator's personal opinion sets the agenda for the overall development of the narrative. The discussion of information depends upon his or her belief towards the legislature's potential repeal effort. Regardless of which side of the debate the narrator represents, the reader views a biased discussion. Yet, as a way of justifying his or her biased discussion of information and issues, the narrator incorporates the artistic proofs of ethos and pathos.

In order to persuade the reader that the narrator is knowledgeable and credible, he or she discusses past and present occupations in the narrative. The narrator's goal with this strategy is to persuade the reader to believe that he or she is credible to discuss the issues within the narrative. This, in turn, will make the reader overlook the narrator's biased presentation.

The narrator also uses pathos, or emotional appeals, to reinforce views. A majority of the discussion within each narrative surrounds the narrator's beliefs regarding assisted suicide, terminal illness, and other closely related issues. By discussing personal situations, fears of death, and experiences with dying patients, the narrator attempts to persuade the reader by appealing to his or her emotions. The narrator wants to pull the reader in emotionally, while persuading him or her to feel a particular way on the potential repeal of Measure 16.

Within all of the secondary source narratives, it is evident that the narrators have a specific goal in mind. This goal is to state their opinions on the Oregon Legislature's involvement in potential repeal of Measure 16 and discuss particular information that will

defend their position. The narrators use ethos and pathos to defend their positions and to persuade their readers to support them on the key issues they discuss.

Conclusions

This study demonstrates several conclusions regarding the role of narrative within public policy. The most evident conclusion resides in the fact that, as a communicative act, narrative continues to represent a common practice people use in order to interact with one another. When the need arises to express beliefs, exchange ideas, and/or promote views, people tend to rely on this form of communication. Within this study, individuals evoke narrative for more than just its practical purposes; they use this communicative form to attempt to persuade others towards a specific political belief. They hope their narratives will encourage readers to act appropriately.

Another conclusion drawn from this study concerns the idea that when a person steps into the role of a narrator, attempting to influence public policy, some very specific things occur within his or her discourse. This includes the idea that each narrator has a personal agenda which helps determine the issues and experiences he or she will discuss. Additionally, the narrator's position on the assisted suicide debate also plays a factor in the development of the discourse. If a person is pro-assisted suicide, he or she creates a narrative which deems the practice as a necessary and viable option which should exist for terminally ill patients. Simultaneously, anti-assisted suicide supporters develop their narrative in a way that presents the practice as unnecessary, problematic, and dangerous to human existence.

Along with a noticeable personal agenda, the narrator relies upon his or her use of ethos and pathos (artistic proofs) to persuade the reader. The narrator uses ethos, or the establishment of one's credibility, to the extent that the entire narrative is created around personal situations and experiences. Additionally, the narrator uses ethos in discussing the relationship he or she has with the cancer patient, listing past and present occupations

which relate to the main issues at hand, and discussing any activity which makes him or her appear more credible about Measure 16 and assisted suicide.

The narrator also uses pathos, or emotional appeals, to persuade the audience. Almost every narrative reviewed is entirely based upon the narrator's use of pathos. By focusing the narrative on personal situations, discussing dying family members, and calling out to fellow citizens for help, the narrator pulls at the reader's "heart strings" as a means of persuading him or her on the issue of assisted suicide.

It is evident that narrators must heavily rely on these artistic proofs in order to persuade their readers. The narrator knows he or she is dealing with an unfamiliar audience; yet, if the ultimate goal of each narrator is to persuade the reader towards his or her views on Measure 16, a strategy is necessary. This strategy involves consistently implementing the artistic proofs of ethos and pathos.

The ironic aspect of the creation of these narratives resides in the fact that the narrators do not bother to include the major arguments of the assisted suicide debate within their discourse. As previously discussed in chapter two, both proponents and opponents of the assisted suicide debate have outlined specific arguments defending their side of the practice. Yet, when the average person attempts to persuade a fellow citizen about assisted suicide, the major arguments of the debate are left out. This shows that while as a whole, each side of the debate may deem these arguments important in persuading people on the issue of assisted suicide, the average person does not. Instead, citizens use the persuasive tactic of promoting a personal agenda which involves establishing credibility and targeting the reader's emotions.

The importance of narrative's role within the passage of Measure 16 varies, depending upon who the participants are in the particular discussion and how informed they are on the power of rhetoric. Gerald Prince (1982) states, "[M]any narratives are valuable not so much qua narratives but rather for their wit, their style, their ideological content, or their physical insight. . . ." (160). While a person views these types of elements

within Measure 16 related narratives, the discourse represents much more than a specific style or wit. In time, these narratives will remain a visible part of what is perhaps the most controversial debate ever confronted in the state of Oregon.

Implications for Future Study

The merits of this study on narrative not only strengthen the validity of narrative theory, but they provide a useful perspective for those who take part in the voting process. By recognizing the role of narrative within initiatives like Oregon's Measure 16, both the study of rhetoric and the study of public policy are broadened. Additionally, this study educates people on the creation of the rhetorical discourse used to sway political beliefs and affect voters during election time. Finally, this study helps contribute to the importance of critical thinking within the voting process. Specifically, it encourages people to rely on the critical study of the issues, rather than simply relying on the strategically crafted discourse in making voting decisions.

Because this single study enhances understanding of public policy and promotes the study of rhetoric, it proves that further study would be beneficial in these areas. Studies expanding previous research on the issues of narrative and assisted suicide would be of specific interest. Because assisted suicide rhetoric exists within a variety of areas, it would be interesting to study the use of narrative among persons other than the voting public. Possible studies could include analyzing the role of narrative among persons within the medical field, government officials, and state and national agencies. These findings could then be compared to the existing research on the ways narrative affects voters.

Additionally, in broadening the study of narrative, one might include gender in the analysis; specifically comparing and contrasting ways in which narrative functions to persuade men and women on the issue of assisted suicide. Not only would this provide an

interesting study on gender, it would expand research within the areas of narrative and public policy.

Finally, looking outside the scope of the assisted suicide debate, it would be of particular interest to study the role of narrative within other controversial debates. Potential studies might include analyzing the role of narrative among persons involved within the latest discussions and rulings in either the abortion or gun control debates.

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APPENDIX

Measure No. 16

ARGUMENT IN FAVOR

My name is Patty Rosen. I live in Bend and work as a medical educator. In 1986, my 26-year-old daughter Jody was diagnosed with terminal bone cancer. Operations, chemotherapy and radiation treatments did nothing to help Jody. Jody knew the remainder of her life would be spent dying ... In agonizing pain ... Without hope.

Jody withstood the pain and mental anguish as best she could, putting on a brave face for everyone. As the cancer grew, Jody developed tumors under her skin. I could no longer comfort my daughter with a hug. It was just too painful for her.

Bedridden, unable to touch and be touched, unable to converse without pain, heavily drugged and hating it, Jody asked for my help in ending her life.

For several months, I resisted, as most mothers would. Could there be a miracle cure? Or a new treatment?

I finally agreed to help her when she told me after another painful chemotherapy session, "Mom, this isn't working. I'm only doing this for you. Won't you let me go please?"

I cried, but I finally agreed. She took the necessary medication herself and I was there when she fell asleep for the last time.

Did I break the laws of government? Yes.

Did I break the more important unwritten laws of love and parenthood? NO!

As Jody died, I crawled into bed with her. For the first time in months, I was able to hold my daughter in my arms as she died in peace.

Jody was a concerned, and caring person who knew exactly what she wanted. It was her right as a capable, rational adult to choose her time of death. Jody would have wanted Ballot Measure 16 to pass, if not to help her, to help the next person like her.

Please vote yes on Ballot Measure 16.

Measure No. 16 | B |

ARGUMENT IN FAVOR

My name is Edythe Steinbock. Several years ago, my husband, Multnomah County Circuit Judge Irv Steinbock, was diagnosed with digestive cancer. Despite every effort, Irv's condition gradually worsened until he was forced to spend his final days in the hospital.

Irv wanted to die in a humane and dignified way, just as he lived his life. He decided to end his life with medication and his doctor agreed to help.

Irv asked our Rabbi if in God's eyes his action would be a sin. Irv's Rabbi gave his blessings and told Irv he would be willing to be present when Irv took the medication.

We told our children. They agreed it was their father's decision and they would certainly be there to support him.

The prescription was written and filled. Because Irv was in a Catholic hospital, he knew he could not take the life-ending medication there.

Irv decided to die at home.

The night before Irv was to come home, he passed away in his sleep. I think the relief he felt knowing that it would soon be over allowed him the peace to die. He was in control of his final day. He was at peace. For that I thank God.

Irv and I had talked often about death with dignity and the need to change the law. Although he was a conservative judge, we both believed with great conviction that government and religious institutions should not inhibit the rights of rational, dying adults who wish to end their suffering.

Irv would have been a strong supporter of Measure 16. That's why I'm working as a volunteer on the campaign. If I can help one person die at peace . . . in control . . . then we have done well.

Please Vote Yes on Ballot Measure 16. Return to dying people the right to control their own end-of-life decisions.

**Edythe Steinbock,
Portland, Oregon**

Measure No. 16

ARGUMENT IN OPPOSITION

**Living through the dying process
taught us how to live and love.**

If there is one lesson I learned during my husband's dying process, it is that the quality of life should not be measured by health. When you are given a short amount of time to live, your perception of what constitutes quality in life changes.

My husband, Bruce, was diagnosed with terminal brain cancer in March of 1992. The neurologist found that he had a tumor 1/3 the size of his brain. At that time, he was given two to six months to live. Our doctor warned us that maybe two of those months would be "good."

All the months were "good." The prognosis was correct. His illness progressed from simple weakness and headache to a total and complete loss of muscle strength. He lived six months.

But, the doctor was wrong about his warning. All six months were good ones. They were perhaps some of the best of our entire life together. Of course, the "good" the neurologist was referring to was the quality of health. For me, the "good" was measured through the quality of relationships.

Relationships grew. Even when my husband was very, very ill, his life was very, very vital -- to him, to me, to our family and to our friends. He was a key participant in our lives. Relationships with others and with one another grew. It was an empowering time. It was an opportunity to be with him, to talk with him and for him to teach us about dying. It strengthened us to live on without him.

I fear the implications of Ballot Measure 16, for it communicates that quality of life is measured only by health. What are the far-reaching implications of this premise?

Please join me in voting against Measure 16.

Laurel Nordlund

Measure No. 16 **D**

ARGUMENT IN OPPOSITION

**A personal message against Measure 16
from a terminally ill cancer patient:**

Fourteen years ago, I was diagnosed with breast cancer. I fought the battle and believed I had won only to hear last January the words I had lived in dreaded fear of: The cancer had come back; this time it was incurable.

I felt devastated! I was in such enormous pain, I could hardly move. I couldn't get to the bathroom; that was so degrading. I didn't have the knowledge or training to even identify the tools to help me cope with my new situation. I cried and cried. I felt I was in a dark, scary, downward spiral, out of control. I wanted to end it. If Measure 16 had been an option, in my days of desperation and pain, I might have chosen it.

Because Measure 16 was not in effect, I could not obtain a prescription for death from my doctor. I turned to him instead for support and pain control. Then hospice was sent in. Together, my doctor and the hospice team made a commitment to me: to keep my pain under control and provide me with the support and equipment that would allow me to have the best quality of life for the time I have remaining.

Today, with aggressive hospice intervention, I'm comfortable. I enjoy living now more than ever. I can't wait to wake up in the morning. I anticipate each day. Life is about quality, not quantity – making every minute count.

I've heard people who have nearly died talk about how much more they appreciate living. It's so true.

I don't know how I'll talk when I come close to death and get sick again but I do know the added days were worth it – days I might never have enjoyed if I had had the choice of assisted suicide.

Please join me in voting NO on Measure 16.

Corrine Harris
Rogue River, Oregon

RECEIVED
MAR 5 1997



4900 Blanton Road
Eugene, OR 97405
March 1, 1997

The Honorable Jo Ann Bowman
State Capitol H-383
Salem, OR 97310

VOTE NO on 2954

Dear Representative Bowman,

Is it any wonder that the public has become cynical about voting, no longer supports a government that ignores its voice, abhors politicians' disregard for the people's choices?

The people of Oregon have gone to the polls and have made an important decision about what they consider a requisite for the quality of life - the choice to have help in dying.

This issue is NOT like measure 47 or other decisions that effect many lives or that can do harm to large numbers of people, particularly children. This is an issue that effects ONE person, the person who feels that they no longer wish to experience pain and/or dependency.

By what right do you ignore that vote and take it upon yourselves to recind that decision? The courts are currently deciding the legality of doctor assisted suicide; surely the legislature is not in a position to make such a decision.

If I might make an analogy, it is as if 68 Oregonians (the number of legislators) took it upon themselves to oust a legislator (whom they did not happen to like) who had been elected to office.

I am 68 years old. I expect to die from cancer. I do not fear death nor even the pain involved. But I am terrified of the debilitating nature of this disease, the demeaning position I will need to endure, and the terrible pain I will cause my family who love me and will suffer for me.

Please don't let this happen to me. I have lived a good and productive life. Let me die with dignity in my own time.

Sincerely,

Dorothy Anker

Dorothy Anker, Ph.D

cc: Senator Susan Castillo

Representative Floyd Prozanski

Letter to the Editor, Eugene Register Guard

Letter to the Editor, Salem Statesman

*Please don't waste this
+ money on a response
I'll watch the
nothing.*

Marian A. Cline
24049 S. Central Point Rd.
Canby, OR 97013

May 7, 1997



House of Representatives
Salem, Oregon

Dear Representative,

House Bill 2954

The voting public needs an opportunity to rethink the Assisted Suicide Bill as it was passed.

When I hear discussion about Assisted Suicide, I hear only a lot of fears. Fear of dying, when actually dying is a part of living. Fear of screaming for pain killers and being denied. This is fear of poor medical management. Fears of being a burden to the family when in reality this is most likely untrue.

I am a retired R.N. with 20 years experience as a Community Health Nurse working in Home Nursing. I have witnessed many instances of the peace and joy of dying in the Hospice setting; Dying at home with family and nurses controlling the pain and other bodily functions.

I recall spending a night in the home of a lady dying of Cancer. She was slipping into her final hours. Her family, her minister and myself were there. We took turns tending to her needs, holding her hand, or just sitting with her. The minister read scripture and we all celebrated her life until 3:00 in the morning when she took her last breath.

In the Cancer ward in the hospital: The patient was walking the halls with her daughters. She was getting weaker because the cancer had closed the tube to her stomach. She could neither eat or drink. She said, "No more treatments." When she could no longer walk the halls, she sat in her room with her family and shared the secrets of her favorite recipies with her daughters and her nurses. One night she passed away.

Another patient in his home: He had severe lung disease. One day he told me, "The Angel of Death was here last night but I turned my back on him. I am going to spend the day with my wife and tonight I'll go with him." He did.

In my personal life: My husband died at the age of 51 of Emphysema. Emphysema is a nasty disease because the lack of oxygen makes them tempromental - not easy to live with. Yet, Our sons and I do not regret those trying times at the end because we were able to put closure to his life and get on with our own lives.

More recently one of those sons died at age 39 of a brain tumor. He became progressively more paralyzed and died at home with his children at his side. Would I or any of the family have wanted his life cut shorter? NO!

Lets not urge people to kill themselves, Lets help them to learn to Live Until You Die.

Sincerely,

Marian Cline

Marian Cline R.N., C.H.N., B.S.



William F. Comer, M.S., R.Ph.
8350 S.W. Sexton Mtn. Ct.
Beaverton, OR 97008

February 22, 1997

To the Elected Officials of the State of Oregon:

I am a pharmacist with over 28 years of hospital, home health, hospice and academic experience and currently work for a home infusion therapy company. I am a retired Colonel from the U.S. Army Medical Service Corp and am on the faculty of the Oregon State University School of Pharmacy. I have also been involved in the development and implementation of Hospice/Hopewell House and have personally provided pharmaceutical care for over 1000 people living with terminal illnesses. I have also been instrumental in working with the Oregon Board of Health and Board of Pharmacy in developing language for the Oregon Death with Dignity Law that enhances pharmacists knowledge of, and participation in, their professional responsibilities. I also serve on the Pharmacist State-wide Task Force on Measure 16.

I believe that it is in the best interest of the citizens of Oregon and the care of people with terminal illnesses, that the Oregon Death with Dignity Law be implemented as written and approved by a majority of Oregonians. The technology of today has been keeping people alive to the extent that we have outstripped our ability to adequately assure their comfort and deliver compassionate care. Although there have been tremendous strides in the development of pain and symptom management, we cannot keep everyone pain and symptom free all the time. People want to have control and have the right to make their own end-of-life decisions. People can now refuse care that extends suffering, so why can they not also have the control to end their own suffering?

I find it more than coincidental that the Catholic Bishop's Conference, two weeks after Measure 16 was passed, ruled that it was now acceptable to stop hydration and nutrition and increase pain medication to "relieve suffering" as long as the intent is not to end life. Previously, this was not an acceptable alternative. Now it is acceptable to "starve one to death" or "sedate one to unconsciousness," but not to allow a person to end their life peacefully with dignity.

The Oregon Death with Dignity Law has many appropriate safeguards and places the individual in control. I know of no health care provider that would want to abuse the system and suffer the incredible consequences. This law, and its implementation, will be closely monitored by both supporters and detractors. Today we have several examples of health care providers assisting people with end of life efforts. How do we know if they are appropriate? The law brings these practices out from the "back alley" and closely monitors and requires appropriate accountability and reporting.

After the United States Supreme Court decides in favor of the constitutionality of this issue, the citizens of Oregon have the right to have their law implemented without change or further delay. To do otherwise would be an insult to our intelligence and individual dignity.

Sincerely,

William F. Comer
William F. Comer, M.S., R.Ph.

RECEIVED
MAY 08 1997



Regarding HB 2954

RECEIVED
MAY 09 1997

reader feedback

Small Business and Community Development
Within the Community, May 31, 1997

Oregonian 5/8/97

Delay in Measure 16 would kill last hope

By PENNY SCHLUETER

For four years, I have been fighting ovarian cancer. I was heartened in 1994 when Oregon voters passed Measure 16, the Oregon Death With Dignity Act. I was comforted knowing I would have an option — a choice — if my final days were a mere existence of pain and increasing debility.

The legal maneuvering by the opponents of Measure 16 to have it declared unconstitutional are bad enough. But now some legislators think the voters of Oregon didn't know what they were doing when they passed Measure 16. The Legislature is debating a law to send Measure 16, the Oregon Death With Dignity Act, back to the ballot.

For me, another year of delay or repeal of Measure 16 may force me to live my final days in agony. Instead of enjoying what is left of my life, I will be forced to worry about the pain, the suffering and the loss of control I may face in my final weeks. I will be forced to worry about hoarding pills, wondering when and how I might end my life — fearing, not death, but those final days and weeks of intolerable pain and increasing debility.

Since January I have watched a legislative committee grapple with this issue. I have at-

tended hearings, and I have testified twice. The very same legislators who now seem so determined to repeal Measure 16 promised me, at the conclusion of my first testimony, that they would not consider any bill to repeal, refer or delay Measure 16.

That was just over a month ago. But now that promise has been broken, and I feel betrayed, for myself and for the 600,000 people who voted yes on death with dignity and for all Oregon voters whose votes on initiatives are being ignored.

I have heard all of the arguments. I have been warned that prescriptions might not work quickly, that it might take a day or more for me to die once I take the medication. But the risk seems minor compared to some of the risk associated with the chemotherapy I

have taken. In every medical treatment, patients and doctors must weigh the risk and the benefits.

Some have told me that doctors would prefer to keep private the practice of helping patients to die, to leave the practice hidden behind closed doors. But that puts compassionate and caring doctors who want to help their patients at risk of legal investigation and loss of license to practice medicine.

The choices of medical treatments near the end of life are very personal choices. Oregon

permits — in fact encourages — living will and medical powers of attorney. The Death With Dignity Act simply legalizes an option many want available.

Some have expressed concerns about dying patients being forced to die. The Oregon Death With Dignity Act ensures that will not happen. In fact, legislators who oppose efforts to send Measure 16 back to the ballot have outlined a series of amendments they want to add to the act, safeguards to assure themselves that this law is workable and that no Oregonian will ever be forced to take life-ending medication without making a rational, capable choice of their own free will.

But even with these amendments, opponents of the law have vowed to push their fight to the floor of the House. Why? Because they just don't agree with the law voters passed. They think we are wrong, and they're going to try to force us to vote again.

If a few more safeguards are all it takes to convince the Legislature to leave Measure 16 alone, I support that effort. But repeal or referral or delay reduces the quality of my life now. It removes the one option that provides me comfort and contentment.

It's wrong for the Legislature to undo your votes. It's worse for them to try to control my death.

Penny Schlueter of Pleasant Hill is a retired economics teacher. Her article was submitted by Barbara Coombs Lee, the chief petitioner for Measure 16.

“ Instead of enjoying what is left of my life, I will be forced to worry about the pain, the suffering and the loss of control I may face in my final weeks. ”