End-of-Life Issues in the United States after Terri Schiavo: Implications for Social Work Practice

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Abstract: *The very public death of Terri Schiavo in 2005 alerted Americans to the growing ethical, medical, and social crises surrounding the status of end-of-life issues and decisions in the United States. Currently, only a few states grant terminally ill patients the right to end their lives, with physicians' help, if they so choose. Public opinion data from 1947 to 2011 report that Americans support greater rights for individuals facing end-of-life decisions—up to and including physician-assisted suicide and euthanasia. This paper considers the status of end-of-life issues in the United States after Terri Schiavo's death and examines the opportunities for advocacy by social workers who serve clients and families encountering this complex and controversial issue.*

Keywords: *Attitudes, death and dying, end-of-life decisions, euthanasia, physician-assisted suicide, right to die*

INTRODUCTION

On February 25, 1990, Terri Schiavo collapsed in her home and never regained consciousness; 15 years later, on March 31, 2005, she died in a Florida hospice. Terri Schiavo's death and the preceding legal battle to remove her feeding tube ignited a firestorm of debate about the status of end-of-life decisions in the United States. Passionate reactions to the case came from all sides: an outraged public, government officials, and the professionals who specifically deal with end-of-life care, notably social workers, nurses, and physicians. This debate revealed how deeply divided the American public is when it comes to euthanasia and end-of-life care. Moreover, these debates serve to highlight just how critical end-of-life issues will become as population demographics increasingly reflect a greater proportion of older Americans.

As Freudenheim (2010) aptly notes, over 40% of elderly hospital patients are 65 or older. In addition, the U.S. Census Bureau (2010) reports that as of 2009, 12.5% of the U.S. population is 65 years of age or older, 5.8% are 75 years of age or older, and 1.5% are 85 years of age or older. Freudenheim further observes that by 2030, more than 70 million Americans will turn 65, with the fastest-growing segment being over 85 years of age. This specific population tends to be costly to treat, has numerous illnesses, and often requires multiple hospital stays. Gardner and Kramer (2010) found that end-of-life care sought by this age group focused on dying with dignity and ignoring additional medical treatment to keep them alive. Similar findings were reported by Leichtentritt (2011), Luptak (2010), Schroepfer and Noh (2010), and Thompson and Chochinov (2010).

In an independent study, the National Hospice and Palliative Care Organization suggests that Medicare reimbursement cuts will potentially harm the financial stability of 66% of hospice programs in the U.S. (Patients Rights Council, 2011). These cuts will

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only further undermine the growing number of elderly who seek to obtain quality end-of-life care from social workers.

Public attention to end-of life issues occurred throughout the 1990s with the controversy surrounding Jack Kevorkian, the Michigan doctor who assisted terminally ill patients in taking their lives (Kirk & Sullivan, 1996), and earlier still with the Karen Ann Quinlan and Nancy Cruzan cases, which both involved women in vegetative states like Schiavo (Pence, 2004). While the names attached to the euthanasia debate have changed over time, the core issues and questions continue today (Boisvert, 2009; Chong & Fok, 2009; de Bal, Gastmans, & Dierckx de Casterlé, 2008; Givens & Mitchell, 2009; Seale, 2009).

Euthanasia is an emotionally, politically, and sociologically charged word that evokes a strong reaction in almost every person. From the ancient Greek word for "good death," euthanasia can be defined more specifically by the following characteristics: active versus passive, voluntary versus nonvoluntary, and the role the physician plays in the act (Leichtentritt & Rettig, 2002, p. 568). The most commonly discussed types of euthanasia are physician-assisted suicide and active voluntary euthanasia. Physician-assisted suicide (PAS) is a practice whereby physicians prescribe medications or some other form of intervention to hasten death for terminally ill individuals (Blevins, Preston, & Werth, 2005). Active voluntary euthanasia (AVE) occurs when a patient requests medical assistance in order to bring an end to life, while passive voluntary euthanasia (PVE) is when life-sustaining treatment is withdrawn from a patient with the patient's permission (Pakes, 2005; Mahmood, 2008). Involuntary or nonvoluntary euthanasia involves the euthanasia of unwilling or incapacitated patients and is less frequently addressed in the euthanasia debate (Allen et al., 2006). Although the practice of involuntary or nonvoluntary euthanasia is rare, it is relevant to the discussion of the Terri Schiavo case, as Schiavo's wishes regarding end-of-life care were contested in the absence of a written document such as a living will.

LITERATURE REVIEW

Physician-Assisted Suicide, Patient Self-Determination, and Oregon's Death with Dignity Act

Controversy over euthanasia and end-of-life decisions has been prevalent since the beginning of the 20th century, but became particularly heated in the early 1990s (Altilio & Otis-Green, 2011). The Patient Self-Determination Act (1990) went into effect nationwide, requiring hospitals, nursing homes, and hospice facilities to provide their patients with legal documents (or advance directives) to convey their decisions about end-of-life care. In 1991, journalist and Hemlock Society founder Derek Humphry published *Final Exit*, a book that gives terminally ill patients detailed instructions for committing suicide (cited in Blendon, Szalay, & Knox, 1992). During the same year, the Michigan Board of Medicine revoked Jack Kevorkian's license to practice medicine after he assisted three people in ending their lives (Kirk & Sullivan, 1996).

While the Patient Self-Determination Act provided a national mandate on living wills, individual states also attempted to resolve questions regarding euthanasia. In 1994, Oregon voters passed the Death with Dignity Act, which allowed residents to request a lethal dose of medication from a physician under a certain set of circumstances (Oregon Death with Dignity Act, 1994). This law was enacted in 1997, legalizing PAS under specific circumstances (Miller et al., 2004; Stevens, 2006), and was upheld by the U.S. Supreme Court in 2006 (*Gonzales v. Oregon*, 2006). Other states followed; in November 1998, Washington approved physician-assisted suicide, and in January 2010, Montana became the third state to legalize the act (Knickerbocker, 2010). As of this writing, only three states allow for physician-assisted suicide. The topic became so controversial and salient that the National Association of Social Workers (2003; 2004; 2009) developed several reports to guide social workers on palliative and end-of-life care.

Demographic Influences on End-of-Life Decisions

Differences between individuals' religious and moral perspectives have led to heated debate over the merit of euthanasia (Gielen, van den Branden, & Broeckaert, 2009). Those who identify as very religious are less likely to support PAS or to consider it for themselves (Domino, 2003). Caddell and Newton (1995) observed a diversity of opinions regarding euthanasia across religions. Catholic and conservative Protestants viewed active euthanasia as more acceptable than suicide and preferred the physician, rather than the patient or family member, to facilitate the dying process. This finding is consistent with the results of a study from Ohio where individuals expressed support for euthanasia when physicians were actively involved and exerted authoritative control over the voluntary procedure (MacDonald, 1998). One such highly publicized example of how strongly polarized Americans are regarding end-of-life decisions involved Terri Schiavo.

The Terry Schiavo Case

In 1990, Terri Schiavo collapsed in her home and never regained consciousness. Despite rehabilitation attempts, Schiavo remained in a persistent vegetative state and was dependent on a feeding tube for nutrition and hydration (Hampson & Emanuel, 2005; Kollas & Boyer-Kollas, 2006). In 1998, Michael Schiavo, Terri Schiavo's husband and guardian, filed his first petition to have Terri's feeding tube removed—which was met with strong objection by Schiavo's family and many right-to-life activists. Terri Schiavo's presumed wishes became the subject of intense national controversy; while Schiavo made comments to friends and family about her desire not to be kept alive artificially, she had not formalized these wishes in an advance directive or living will (Ditto, 2006). In the absence of such a directive, the courts were forced to resolve the question of Schiavo's death or continued life in a persistent vegetative state (Preston & Kelly, 2006).

In 2003, a Florida court issued a second order to remove Schiavo's feeding tube. The Florida legislature passed HB-35E or "Terri's Law" in response. "Terri's Law" granted Florida Governor Jeb Bush the ability to name a new guardian for Schiavo and prevent the removal of Schiavo's feeding tube (Kollas & Boyer-Kollas, 2006). By 2005, the U.S. President, George W. Bush, and several members of Congress had become involved in the Schiavo case. Congressional involvement began the day after the removal of Schiavo's feeding tube on March 18, 2005, when two Republican senators announced that they would call Schiavo to testify before a congressional committee. Republican leaders in the House of Representatives followed suit by subpoenaing Schiavo, effectively placing her under federal protection and barring any attempts to remove her feeding tube. Congress additionally passed S.686, or the Palm Sunday Compromise, to place the Schiavo case under federal jurisdiction.

President George W. Bush signed the Palm Sunday Compromise after the bill passed, and he also created the Protection of Incapacitated Persons Act of 2005 (Hampson & Emanuel, 2005). On March 31, 2005, Terri Schiavo died 13 days after her feeding tube was removed. Since the Schiavo case, euthanasia and end-of-life care have continued to stir strong emotions among the American people (Bern-Klug, 2010; Gorsuch, 2009) and have generated a great deal of research (Smith, Goy, Harvath, & Ganzini, 2011).

METHODS

The findings of this study are based on published opinion polls from the Gallup Organization (1996; 2006a; 2006b; 2007a; 2007b; 2011) and the National Opinion Research Center/General Social Survey (Benson, 1999). The design of the sample for personal (face-to-face) surveys is that of a replicated area probability sample down to the block level in the case of urban areas and down to segments of townships in the case of rural areas. After stratifying the nation geographically and by size of community according to information derived from the most recent census, over 350 different sampling locations are selected on a mathematically random basis from within cities, towns, and counties that have, in turn, been selected on a mathematically random basis.

The procedures just described are designed to produce samples that approximate the adult civilian population (aged 18 and older) living in private households (that is, excluding those in prisons, hospitals, hotels, and religious and educational institutions, and those living on reservations or military bases) and, in the case of telephone surveys, households with access to a telephone. Survey percentages may be applied to census estimates of the size of these populations to project percentages onto the numbers of people. The manner in which the sample is drawn also produces a sample that approximates the distribution of private households in the United States; therefore, survey results can also be projected onto the number of households.

RESULTS

Attitudes toward Euthanasia for Patients Who Have an Incurable Disease, 1947-2007

Between 1947 and 2007, a cross section of the American public was asked the following question (see Table 1): "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?" The results reveal consistent majority support for voluntary active euthanasia (VAE) since the question was first posed in 1947.

Table 1: **Attitudes toward Euthanasia for Patients Who Have an Incurable Disease, 1947-2007**[a]

Year	Yes %	No %	Don’t Know/NA %
1947	54	37	9
1950	54	36	10
1973	53	40	7
1977	60	36	4
1978	58	38	4
1982	61	34	5
1983	63	33	4
1985	64	33	3
1986	66	31	4
1988	66	29	5
1989	66	30	4
1990	69	26	5
1991	70	25	5
1993	65	30	5
1994	68	27	5
1996	68	28	4
1998	68	27	6
2001	65	31	4
2002	72	26	2
2003	72	25	3
2004	69	29	2
2005	75	24	1
2006	69	27	4
2007	71	27	2

Question: “When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient’s life by some painless means if the patient and his family request it?”

[a] Figures may not total 100% because of rounding.

For each table, authors have reported all data which were collected by Gallup Organization and other major polling organizations. However, it is important to note that these organizations did not conduct the same survey every single year, which explains the occasional gaps in the data reported year to year.

Source: Poll data compiled Benson (1999) and Gallup Organization (2006b; 2007b).

In 1947, 5 in 10 Americans supported a patient’s right to end his or her life when that person was suffering from a terminal illness. Beginning in 1977, American attitudes toward euthanasia began to change and support for VAE steadily increased, with 6 in 10

Americans agreeing that a patient with a terminal illness had the right to end his or her life. By 1991, 7 in 10 Americans supported euthanasia. By 2005, fully 3 in 4 Americans (75%) supported euthanasia, and this figure leveled off to 7 in 10 by 2007.

Support for Doctor-Assisted Suicide by Major Social Demographic Factors, 2003-2006

From 2003 to 2006, a cross section of the American public was asked two significantly different questions: (1) "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?" (see column 1, Table 2) and (2) "When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it? (see column 2, Table 2)."

This variation in wording—"end[ing] the patient's life by some painless means" versus "assist[ing] the patient to commit suicide"—yielded strikingly different results. As shown in Table 2, while over 7 in 10 Americans support euthanasia according to this set of questions, in contrast, fewer than 6 in 10 indicate support of euthanasia when the word "suicide" was used. Without exception, the responses to the questions referencing "suicide" resulted in lower levels of support in every demographic category.

Table 2 details how responses to these questions broke down by gender, age, race, education, religion, church attendance, political affiliation, and political ideology. Support for euthanasia ranges from a low of 54% of Americans who attended church almost weekly to a high of 84% of those Americans who report no religious preferences whatsoever. Frequency of church attendance yields the greatest difference in the survey: from a low of 54% of those reporting weekly or almost weekly church attendance compared with fully 80% of those who seldom or never attended church—a significant 26% difference. When we address the issue of physician-assisted suicide in the second column of Table 2, church attendance again yields the sharpest difference. For those Americans who report weekly or almost weekly attendance, fewer than 4 in 10 (39%) compared to over 7 in 10 (72%) of those who report seldom or never attending church support a patient's right to physician-assisted suicide.

The second sharpest division in attitudes on the issue of physician-assisted suicide is reported between white and black Americans. Fully 6 in 10 white Americans compared to fewer than 4 in 10 black Americans support physician-assisted suicide.

Attitudes toward the Moral Acceptability of Physician-Assisted Suicide, 2001-2011

From 2001 to 2011, a cross section of the American public was asked the following question (see Table 3): "Regardless of whether or not you think it should be legal… please tell me whether you personally believe that in general it [doctor-assisted suicide] is morally acceptable or morally wrong?"

Table 2 **Support for Doctor-Assisted Suicide by Major Social Demographic Factors, 2003-2006** [a]

	Support doctor ending patient's life by painless means %	Support doctor assisting patient to commit suicide %
Total sample	69	58
Gender		
Men	73	57
Women	65	58
Age		
18- to 29-year-olds	69	56
30- to 49-year olds	72	63
50- to 64-year olds	69	60
65 years and older	62	47
Race		
Whites	70	60
Blacks	56	38
Education		
High school or less	65	48
Some college	69	60
College graduates	76	70
Post-graduate education	73	69
Religion		
Protestants	61	50
Catholics	71	62
No preference	84	81
Church Attendance		
Weekly/almost weekly	54	39
Monthly	68	59
Seldom/never	80	72
Party Affiliation		
Republicans	63	50
Independents	71	61
Democrats	72	61
Political Ideology		
Conservatives	57	44
Moderates	74	65
Liberals	82	70

Question: “When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?
Question: “When a person has a disease that cannot be cured and is living in severe pain, do you think doctors should or should not be allowed by law to assist the patient to commit suicide if the patient requests it?”
[a] Figures may not total 100% because of rounding.
For each table, authors have reported all data which were collected by Gallup Organization and other major polling organizations. However, it is important to note that these organizations did not conduct the same survey every single year, which explains the occasional gaps in the data reported year to year.
Source: Poll data compiled by Gallup Organization (2006b).

Table 3 **Attitudes toward the Moral Acceptability of Physician-Assisted Suicide, 2001-2011[a]**

Year	Morally acceptable %	Morally wrong %	Depends on situation (vol.) %	No opinion Not a moral issue (vol.) %
2001	49	40	8	3
2002	50	44	4	2
2003	45	49	5	1
2004	53	41	3	3
2005	49	46	4	1
2006	50	41	6	2
2007	49	44	5	2
2008	51	44	3	1
2010	46	46	6	2
2011	45	48	5	2

Question: “Regardless of whether or not you think it should be legal… please tell me whether you personally believe that in general it [doctor-assisted suicide] is morally acceptable or morally wrong?”
[a] Figures may not total 100% because of rounding.
For each table, authors have reported all data which were collected by Gallup Organization and other major polling organizations. However, it is important to note that these organizations did not conduct the same survey every single year, which explains the occasional gaps in the data reported year to year.
Source: Poll data compiled by Gallup Organization (2011).

The results of this decade-long survey reveal remarkably stable American public opinion varying only 8 percentage points over 10 survey periods. That is, those reporting moral acceptability of physician-assisted suicide ranged from a low of 45% in 2003 and 2011 to a high of 53% in 2004. Thus, over the last decade, we note that a majority or near majority of Americans report that physician-assisted suicide is morally acceptable.

American Attitudes toward the Terri Schiavo Case, 2006-2007

In 2006 and 2007, a cross section of the American public was asked the following three questions (see Table 4): 1) "Should the feeding tube have been removed from Terri Schiavo?", (2) "How do you view Congress's involvement in the Terri Schiavo case?", and (3) "Do you approve or disapprove of the way George W. Bush is handling… the Terri Schiavo case?"

Table 4: American Attitudes toward the Terri Schiavo Case, 2006-2007[a]

	Should have %	Should not have %
Removal of feeding tube	52	42
	Approve %	Disapprove %
Congressional handling of case	20	76
Presidential handling of case	34	53

Question: "Should the feeding tube have been removed from Terri Schiavo?"
Question: "How do you view Congress's involvement in the Terri Schiavo case?"
Question: "Do you approve or disapprove of the way George W. Bush is handling… the Terri Schiavo case?"
[a] Figures may not total 100% because of rounding.
For each table, authors have reported all data which were collected by Gallup Organization and other major polling organizations. However, it is important to note that these organizations did not conduct the same survey every single year, which explains the occasional gaps in the data reported year to year.
Source: Poll data compiled by Gallup Organization (2006a; 2007a).

When asked about the removal of Schiavo's feeding tube, a bare majority (52%) of Americans believed that Schiavo's feeding tube should have been removed. When polled about congressional and presidential handling of the Schiavo case, Americans were decidedly opposed to congressional involvement in the Schiavo case: only 1 in 5 Americans approved. Similarly, barely 1 in 3 Americans approved of President George W. Bush's handling of the Schiavo case.

DISCUSSION

Since 1947, American support of VAE has steadily increased. This trend suggests that Americans are increasingly sensitive to the plight of terminally ill patients and are more willing to support euthanasia under certain circumstances. The Terri Schiavo case made national news, as did the cases of Nancy Cruzan and Karen Ann Quinlan, and thereby raised critical questions regarding quality of life for individuals in a persistent vegetative state. This undoubtedly played a role in changing public sentiment regarding euthanasia and PAS (Kollas & Boyer-Kollas, 2006). It is interesting to note that increased support for both PAS and VAE corresponded with media attention generated by Jack Kevorkian, who began assisting patients in ending their lives in the early 1990s (Kirk & Sullivan, 1996).

In 1997, Oregon became the first state to legalize physician-assisted suicide or PAS. The Oregon Death with Dignity Act allows physicians to write prescriptions for lethal doses of medication for terminally ill patients who request such medication in writing (Okie, 2005). Patients must be physically and mentally capable of making the request, and two witnesses must affirm the patient’s wishes. Further, one witness must be unrelated to the patient and not be entitled to any financial benefit from the patient’s death. Once the patient has made such a request, a mandatory 15-day waiting period applies, during which time the patient may cancel the request (Miller et al., 2004). It is important to note that doctors are not required to help a patient end his or her life and that any physician who assists a patient does so voluntarily.

While clear support for PAS existed in Oregon, which created the law, and among American citizens in other states, the federal government still took strong measures to render the law ineffective and override Oregon voters’ decision. As with the Terri Schiavo case, both Congress and the executive branch became involved. In 2000, the U.S. Senate and House of Representatives attempted to nullify the Oregon Death with Dignity Act through the creation of the Pain Relief Promotion Act (Klinck, 2001). In 2002, U.S. Attorney General John Ashcroft attempted to invoke the Controlled Substances Act to prevent doctors from prescribing Oregon residents with lethal doses of medication—an attempt a federal judge later overruled (Johnson, 2002). These strong parallels to federal involvement with the Schiavo case are noteworthy in that they speak to the disconnect that exists between public opinion toward death-and-dying issues and the attitudes and actions of the government.

Concerns related to end-of-life issues involve many professions in the arena of health care, social services, and law. Care-giving professions such as physicians, nurses, and social workers have the responsibility to adhere to current law, carry out patients’ wishes to the extent possible, and continue to advocate for patients and family members encountering the challenges of end-of-life decisions. The social work and larger medical community have a responsibility to adhere to current law, even when some physicians desire to honor their patients’ wishes. A patient’s mental competency is a heavily weighted determinant as to whether he or she might request physician-assisted suicide.

Implications for Social Work Practice

End-of-life care will undoubtedly continue to have significant implications for social workers. Euthanasia, advance directives, and death-and-dying issues are often accompanied by grief, loss, chronic illness, and questions about morality, religion, family relationships, and responsibility. Social workers are uniquely equipped to support patients and families encountering the challenges of end-of-life decisions.

The National Association of Social Workers [NASW] (2003) has developed a pertinent policy statement to assist social workers in working with end-of-life decisions and terminal patients. NASW mandates that social workers have a critical role assisting individuals with their end-of-life options without the use of coercion. Self-determination is a core value for social workers. Towards this end, these individuals should make their own decisions after all options are made known to them. NASW (2004) does not take any specific position on issues dealing with end of life; they are much more concerned with the care of the individual during this time, especially with children and those with developmental disabilities and/or mental illnesses.

NASW’s (2009) updated statements on end-of-life care (pp. 114-120) and hospice care (pp. 186-191) were adopted by their delegate assembly in 2008. These two policy statements are the result of the assembly’s systematic approach to policy development and guide NASW’s advocacy efforts in social policy. Each statement provides approximately 25 policy recommendations that guide social workers’ practice in this field. In addition to the NASW policy statements on end-of-life care, there are a variety of other resources that social workers can draw from. For example, University of Washington School of Medicine (2009) guidelines require physicians to abide by a set of duties and responsibilities. As well, the National Hospice and Palliative Care Organization also provides a variety of resources useful for social workers (Patients Rights Council, 2011).

It is an important responsibility for social workers to become knowledgeable concerning end-of-life issues. The responsibility to take action to withdraw actual life support appliances falls within the responsibility of the medical profession, a heavy responsibility that calls for legal sanction and personal and professional management on the part of the particular health provider. Ethically, the social worker can only refer their clients and families to professionals that specialize in these types of issues (NASW, 2003, 2004).

This study suggests that the American public supports terminally ill patients’ right to choose physician-assisted suicide under specific circumstances, even though this right is currently unavailable in most states. Social workers serve families and individuals facing end-of-life decisions and have the potential to act as advocates for the rights of terminally ill patients. Advocacy at mezzo- and macro-levels can help impact policy. Figueira-McDonough (1993) describes policy practice as the “neglected side of social work interventions” (p. 179). She articulates four approaches to policy practice—legislative advocacy, reform through litigation, social action, and social policy analysis—which we apply here in hopes of inspiring such work.

Legislative Advocacy

Although a majority of the American public clearly supports legalizing PAS and euthanasia, this option is only currently available in a few states. Social workers may interpret this disparity to mean that a majority of Americans' voices are not being heard and that an extremely vulnerable portion of the population—the terminally ill—is not being served or having its interests represented.

It is imperative that social workers organize to lobby for the opportunity of people to preserve the right to determine the course of their own lives. Social work practitioners can work within the ethical framework of the NASW to organize the American public to influence legislation and end-of-life laws so that personal choices will be honored for the terminally ill and their families (Allen et al., 2006; Csikai & Bass, 2000).

It is interesting to note the various legislative efforts across the U.S. attempting to legalize physician-assisted suicide. From January 2011 through June 2011, at least seven bills had been introduced (Patients Rights Council, 2011). Montana, Oregon, and Washington have produced annual reports documenting the implementation of physician-assisted suicide and end-of-life care (Montana Legislative Services, 2011; Oregon Department of Human Services, 2011; Washington State Department of Health, 2011). These reports may serve as exemplars for other states seeking to pass similar legislation.

Reform through Litigation

Individuals who investigate euthanasia as an option to end their lives are typically affected by chronic pain and/or terminal illness. Americans would greatly benefit from reform through litigation because elected officials have been unwilling to represent the wishes of a majority of the American public with regard to end-of-life issues. Social workers are qualified to represent the community's wishes and should work toward reform through litigation to correct often unresponsive and non-representative state and federal laws regarding PAS and euthanasia.

Several recent litigation cases have explored the rights of patients to physician-assisted suicide (see *Baxter v. State*, 2009; *Smith v. State*, 2009). These cases can serve as informational models for social workers as they use litigation advocacy to facilitate their patients' rights to quality end-of-life care. Overall, current laws are not favorable for patients and their families seeking end-of-life care (Frank & Anselmi, 2011). Thus, if social workers implement these and similar models, it may serve to expedite and facilitate the litigation process.

Meisel and Cerminara (2010) provide a comprehensive (nearly 1400-page) book on statutory and case law addressing the issue of end-of-life care. Social workers may find this detailed manual to be an effective resource which they may dawn from to implement reform through litigation.

Social Action

Although each approach has the potential to improve the rights of terminally ill patients in the United States, community-based social action may be more accessible to social workers than reform through litigation because social workers receive formal training in social action techniques as opposed to technical legal training. Social workers could employ this approach on a local level by establishing ongoing dialogue within their community about end-of-life issues and by mobilizing community players and elected officials for change.

Knowledge of public opinion data, like those presented here, could aid social workers in their work toward expanding the rights of terminally ill patients. Specific findings in this article—such as how support for euthanasia and PAS has grown over time and has consistent majority approval—may be important "leverage points" that social workers can use to advocate for the rights of the terminally ill. Social workers should also become aware of George Soros's *Project on Death in America*, which has provided funding to raise awareness in the field of palliative medicine and thereby improve end-of-life care (McGlinchey, 2004).

Social Policy Analysis

Social workers would benefit by becoming familiar with the provisions and status of the Oregon Death with Dignity Act, as this may be pertinent to any end-of-life discussion in their community. Becoming knowledgeable about the provisions of the act, such as who has been impacted by it and how families have been affected, has the potential of being highly persuasive in any public debate. If state legislation proposed the expansion of the rights of terminally ill patients, social workers could take the lead in testifying regarding meeting the needs of this vulnerable segment of the population.

The status of social work practice after the Terri Schiavo case could be likened to the calm after a storm or, perhaps, the calm before an even larger storm to come. Although Terri Schiavo's story no longer dominates the national news, the record number of Baby Boomers nearing retirement means that end-of-life issues will only become more pressing. In the wake of the Schiavo case, only half of Americans had a written will and fewer still (40%) had a living will or advance directive (Gallup Organization, 2005). What this means for social workers is that many Americans may become terminally ill or fall into a vegetative state without any thorough discussion of their end-of-life care. This often leaves the burden to their families to struggle through inadequate, vague, and often archaic laws to ensure the most dignified and painless end-of-life arrangements for their loved ones.

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