zations, and professional movements rather than in the seclusion of hospitals
and courtrooms. What had been a private problem of death had become poli-
tical, and what had been the subject of personal discussions became a fiery sub-
ject of public debate.

This context made it safer for key physicians and leaders to mobilize sup-
port for further legal reform. Polls of physicians, and the actions and state-
ments of physicians' groups that have campaigned in favor of ballot measures
and spoken in favor of federal claims, indicate that there are many physicians
who treat dying patients who want to do more for them. But doctors like Tim-
othy Quill in New York and Peter Goodwin in Oregon claimed they could not
practice end-of-life medicine any better without professional and legal acqui-
escence in helping patients to exercise choice before death is imminent.

Some physicians said they were reluctant to help patients to die for fear
of being drawn in—"It's difficult to act in the present legal climate." Some
crossed the line. Operating in fear, they linked up with leaders in the legal pro-
fession, and this professional alliance advocated reform of assisted suicide law.
For physicians who felt that the present legal climate put them at risk—profes-
sionally and legally—a decision by the people at large to change the law
seemed both desirable and worth pursuing.

As patients demanded better end-of-life care, doctors who heard the calls
for change lamented that their hands were tied by current law. Like physicians
willing to challenge the abortion laws a generation before (Joffe 1995; Reagan
1997), some went public with the claim that legal change was needed, and soon
public discourse included the subject of dying. Physicians who treated dying
patients found themselves caught between several forces: progressive expec-
tations of patients, laws prohibiting assisted suicide, and the professional bias
against accepting death. As more physicians questioned current practices,
public support for physician-assisted suicide expanded.

FRAMING ARGUMENTS FOR AND AGAINST REFORM

A major activity of the death with dignity movement has been to gain legiti-
macy for its claims by linking them with broadly accepted cultural values and
beliefs. This linkage is a process known as "frame alignment" (Snow, Rochford,
Worden, and Benford 1986). Snow et al. contend that the mobilization and
activation of participants are contingent upon "the linkage of individual and
[social movement organization] interpretive orientation, such that some set
of individual interests, values, and beliefs and organization activities, goals and
ideology are congruent and complementary" (Snow et al. 1986:464). To be suc-
cessful, social movement organizations must mobilize potential adherents and
constituents. To do this they identify events and conditions relevant to move-
ment goals, interpret them in agreeable terms, and assign them favorable meanings. This is what is meant by framing. Frame alignment is successful when it succeeds in mobilizing potential adherents and constituents, garnering bystander support, and demobilizing antagonists (Snow et al. 1986).

Frame alignment processes differ between the constraints inherent in different reform strategies. As later chapters will show, proponents and opponents of reform resorted to different discourses and tactics depending on whether they were in court or running a ballot initiative campaign. However, despite these differences, social movements scholar Valerie Jenness makes it clear that “frame alignment processes nonetheless remain critical to the successful negotiation of the larger socio-political environment that crusaders of any type must participate in and ultimately be responsive to” (Jenness 1993:121).

Proponents of expanding the right to die continuously situated the death with dignity movement firmly within larger publicly legitimated issues and community values. As this book will demonstrate, the death with dignity movement has symbolically and literally linked the right to seek a physician’s active, intentional assistance in causing death to principles and beliefs emanating from the right-to-die movement, the movement to decriminalize the harm caused by criminalization of activities that are happening anyway (e.g., drugs, abortion), and the larger efforts in this nation and others to bolster the position of patients against the harms of the medicalization of life. These issues and their attendant discourse constitute not only the political backdrop for the death with dignity movement but also a rhetorical and cultural resource for it.

As later chapters describe, the death with dignity movement has gained support from earlier legal changes based on compassion for suffering. As Schneiderman and Jecker have explained, “[M]edical treatment has come to be viewed by many as an unleashed menace rather than as a beneficent healing process” (Schneiderman and Jecker 1995:40). The perception that modern medicine does little to reduce suffering has been a major impetus for the right-to-die movement.

In 1958, Glanville Williams, a British scholar of jurisprudence, argued for legal reform of euthanasia laws as a way of preventing cruelty to patients and relatives: “Those who plead for the legalization of euthanasia think that it is cruel to allow a human being to linger for months in the last stage of aging, weakness and decay, and to refuse him his demand for merciful release” (Williams 1969:134). Williams’s urgings seem to have anticipated the arguments by physicians like Timothy Quill and others who would lead American physicians in the movement for assisted suicide reform in the 1990s. Quill wrote: “A patient’s request for assisted death often seemed simultaneously legitimate, heartbreaking, and terrifying to the caregivers. Watching patients beg
for assistance that did not come seemed cruel, adding a final humiliation to a process that was already grueling and undermining” (Quill 1993:130–131).

Reformers argue that patients with terminal illnesses are primarily asking for refuge from suffering, which they characterize as unwanted, horrible, and essentially unproductive. This desire for compassion was articulated in campaign ads during all three state ballot initiative campaigns (Chapters 2–4) and in legal arguments presented in two federal court challenges (Chapter 5).

A second primary rhetorical and cultural resource that has been offered in support of reform is patient autonomy. Following the rulings of abortion cases from Roe v. Wade (1973) through Planned Parenthood v. Casey (1992) and contraception cases that preceded them, like Griswold v. Connecticut (1965), liberty and privacy concerns have dominated legal arguments. Many interest groups claim that Planned Parenthood v. Casey (1992) squarely affirmed the constitutional basis for liberty and privacy. A quote from Casey appeared in many amicus briefs when the issue of assisted suicide was taken up by the federal courts:

> It is settled now... the Constitution places limits on a State’s right to interfere with a person’s most basic decisions about family and parenthood, ... as well as bodily integrity. (Brief of Amici Curiae Legal Defense and Education Fund, Inc., et al., at 9, to the United States Court of Appeals for the Second Circuit 95–7028, citing Casey at 849 in support of reversing Quill v. Vacco 870 F. Supp. 78 (S.D.N.Y. 1994))

Judges also reasoned that principles of choice and autonomy provide a legal basis for reformers’ claims. Federal Judge Barbara Rothstein rooted part of her 1994 District Court opinion in this manner:

> The liberty interest protected by the Fourteenth Amendment is the freedom to make choices according to one’s individual conscience about those matters which are essential to personal autonomy and basic human dignity. There is no more profoundly personal decision, nor one which is closer to the heart of personal liberty, than the choice which a terminally ill person makes to end his or her suffering and hasten and inevitable death. (Compassion 1 1994, at 16)

Rothstein’s ruling was taken up by reformers: They used it as a powerful rhetorical source for framing briefs and oral arguments for the Supreme Court (Chapter 5).

Compassion and autonomy were the primary frames used by reform proponents. Compassion and autonomy evoke emotion, especially when linked
to people's fears of a lingering death filled with pain and suffering. Emotional arguments made empirical frames seem less academic. The primary empirical claim asserted by reformers was that assisted suicide ought to be legalized because it happens already. That claim actually consisted of two arguments. One was that other medical practices at the end of life are essentially no different from assisted suicide. The other was that legalization would facilitate proper regulation of a now-secret practice.

Some of the argument for legalizing physician-assisted suicide has stemmed from the observation of Quill and others that with the practice of terminal sedation and the principle of double effect, de facto decriminalization already exists. Quill describes the basic premise of the ethical principle of double effect:

In comfort care, unintended shortening of a patient's life can be accepted as a potential side effect of treatment, provided the primary purpose of the treatment is to relieve suffering. The underlying religious and ethical principle is called the "double effect," which absolves physicians from responsibility for indirectly contributing to the patient's death, provided they intended purely to alleviate the patient's symptoms. It places considerable weight on the physician's unambiguous intent to relieve suffering and not to intentionally shorten life. (Quill 1993:78)

Like prior reformers who successfully argued and mobilized for changes in abortion, gambling, or marijuana laws, the proponents of euthanasia legal reform have argued that the use of morphine at the end of life is a form of de facto decriminalization of assisted suicide. Under the "double-effect" theory, doctors are not considered to have acted unethically—nor are they subject to criminal prosecution—if they prescribe or administer potentially lethal levels of drugs with the intent to ease pain, not cause death. Activist physicians like Quill aim to bring secret practices into the open—employing a classic argument for the change of a de facto practice to a de jure legalized or decriminalized practice. In the words of a New York Times editorial, it is only a matter of sanctioning what already happens with "a wink and a nod" ("Assisted Suicide and the Law" 1997:A12). As we describe in Chapter 6, even Congress's Pain Relief Promotion Act of 1999, which undermines Oregon's assisted suicide law, sanctions the principle of double effect.

To date, the authority to define this distinction between killing and letting die has been kept within the boundaries of the medical profession. This is what sociologists of law mean when they refer to the "medicalized" approach, and the medicalized approach to laws regulating hastened death are very much a parallel to abortion law before Roe v. Wade (1973). For better
or for worse, a medicalized approach to death and the law provides a powerful source for frame alignment efforts.

But the very same medical profession has enabled Dr. Quill and many other health care leaders to reject mainstream thinking. Here there is another parallel to abortion reform efforts:

By the late 1960s, esteemed members of the [medical] profession no longer needed to attack abortion to prove their purity and could challenge laws promoted by their forebears without having their reputations questioned. The legalization of abortion gained great medical and popular support in these years. (Reagan 1997:234)

The right-to-die movement of the 1970s and 1980s brought the issue of hastened death onto public, professional, religious, and legal agendas. Physicians like Quill and Goodwin took calculated risks by framing their claims in generally held, historically meaningful values and beliefs.

As a final example of frame alignment processes, we consider the widely salient frame of economic discrimination. As will be discussed later, the typical economic argument against assisted suicide is that poor people will be enticed to choose death more systematically than people who can afford high-cost medical care. But a more novel argument advanced by legal philosopher Ronald Dworkin was presented in papers submitted to the Supreme Court (see Chapter 5). Dworkin contends that what we have currently is a two-tiered system that provides "a chosen death and an end of pain outside the law for those with connections and stony refusals for most other people" (Dworkin 1997:41). Dworkin's argument that laws that follow the medicalization of death favor "fortunate people who have established relationships with doctors willing to run the risks of helping them to die" can be seen both as a prediction of impetus for change and a resignation that the current system may prevail:

The sense that many middle-class people have that if necessary their own doctor "will know what to do" helps to explain why the political pressure is not stronger for a fairer and more open system in which the law acknowledges for everyone what influential people now expect for themselves. (Dworkin 1997:41)

These debates are really debates about how to define what is happening already. But whether the principle of double effect as it is currently argued in legal, ethical, and clinical usage is biased or not, there actually is an empirical dimension to the claim that "it happens already." That dimension touts the benefits of regulation and oversight if all types of hastened death were decrim-