inalized de jure. One of the principle assertions of this frame is that de jure decriminalization is the easiest road to reducing the harms that accompany criminalization of activities that occur irrespective of their legality. Powerful examples of this frame are laws regarding drug abuse and addiction and laws regulating abortion.

We want to illustrate this example of frame alignment with a rather low-key example that did, however, cultivate wide and serious scholarly interest. The Bay Area Network of Ethics Committees developed procedural guidelines for clinicians faced with a patient’s request for a hastened death. Borrowing the concept of “harm reduction” from the field of addiction medicine and epidemiology, the network achieved a consensus:

First, it is recognized that a potentially dangerous behavior is occurring and will likely continue regardless of legal and social prohibitions. Then interventions or other policies are offered that might lessen the negative consequences of the behavior without sanctioning the behavior itself. (Heilig et al. 1997:370)

As empirical examples of the harm reduction approach, Heilig et al. (1997) cited the use of methadone in the treatment of heroin addiction and needle exchange programs to quell the spread of HIV infection.

Opponents of death with dignity also must pursue frame alignment. They have linked assisted suicide with the potential for abuse, fear of a slippery slope, and a likelihood that alternatives to assisted suicide will be neglected. The history of euthanasia in the Netherlands is cited often.

The Achilles’ heel of the death with dignity movement is the claim that the law would be used by the wrong people for the wrong reasons (Coombs Lee 1997). Some will resort to assisted suicide because they are depressed. Others will seek to avoid spending the family nest egg. That risk includes the possibility of coercion. Poor people with few options might be subtly forced into assisted suicide. Marginalized patients, such as the infirm elderly, the permanently disabled, and people with illnesses such as AIDS, might succumb to societal discrimination.

Opponents have aligned these potential abuses with people’s memories of Nazi Germany. Even when proponents counterargue that modern proposals are grounded in compassion, not genocide, opponents turn to the history in the Netherlands—effectively arguing that any distinctions between compassionate euthanasia and genocidal euthanasia are more gray than black and white. Nat Hentoff, noted civil libertarian thinker and writer for the Village Voice and Washington Post, warns about “the small beginnings of
death," observing that in every culture and time period, what began as help for a few people to achieve a good death in hard cases soon became a regular practice of controversial if not downright egregious hastening of death (Hentoff 1988).

In 1994 the New York State Task Force on Life and the Law, commissioned by New York Governor Mario Cuomo, issued a 217-page report—*When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*—urging against legalizing assisted suicide and euthanasia. The Task Force warned that:

>The risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantages, would be extraordinary. (New York State Task Force on Life and the Law 1994:120)

The Task Force was careful to point out that:

>This risk does not reflect a judgment that physicians are more prejudiced or influenced by race and class that the rest of society—only that they are not exempt from... the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. (New York State Task Force on Life and the Law 1994:125)

A related set of opposition arguments and frame alignment processes is fear of a slippery slope. Here the fear is that laws that permit competent patients to voluntarily end their lives will eventually be expanded to incompetent patients who never asked for such "treatment." Distinguished law school professor Yale Kamisar asks:

>If personal autonomy and the termination of suffering are supposed to be the touchstones for physician-assisted suicide, why exclude those with non-terminal illnesses or disabilities who might have to endure greater pain and suffering for much longer periods of time than those who are expected to die in the next few weeks or months? (Kamisar 1996:88)

It is this opposition frame that most directly deflates proponents' framing efforts regarding compassion and autonomy. For if compassion and
autonomy are the key reasons for permitting people to control the timing and manner of death, why should the law limit death with dignity to only a few?

University of Chicago Professor Leon Kass, M.D., urges that assisted suicide, once legalized, will not remain confined to those who freely and knowingly elect it:

The enactment of a law legalizing mercy killing (or assisted suicide) on voluntary request will certainly be challenged in the courts under the equal protection clause of the Fourteenth Amendment. Why, it will be argued, should the comatose or the demented be denied the right to such a dignified death or such “treatment” just because they cannot claim it for themselves? (Kass 1991:473)

Kass points out that laws permitting competent patients to refuse treatment or to have treatment discontinued have been expanded to include nearly everyone, and he sees no reason why assisted suicide laws would not evolve (Kass would say “devolve”) similarly: “With the aid of court-appointed proxy consenters, we will quickly erase the distinction between the right to choose one’s own death and the right to request someone else’s—as we have already done in the termination-of-treatment cases” (Kass 1991:473).

In Cruzan v. Director (1990), the Supreme Court tacitly approved the right of surrogate decision makers to act on behalf of permanently unconscious patients. The court cited a line of influential cases from California. That line of cases evolved into the concept that “by permitting the conservator to exercise vicariously a patient’s right to choose, guided by his best interests, we do the only thing within our power to continue to respect him as an individual and to preserve his rights” (Conservatorship of Drabick 1988, at 855).

Drabick and Cruzan, therefore, provide widely accepted cultural values and beliefs that suggest there is a slippery slope. Opponents of death with dignity have aligned their arguments that physician-assisted suicide would not be limited to competent, terminal patients who make voluntary requests with known history.

Furthermore, again, the practices in the Netherlands have been used to frame opposition arguments about a slippery slope:

During the past 2 decades, the Netherlands has moved from considering assisted suicide (preferred over euthanasia by the Dutch Voluntary Euthanasia Society) to giving legal sanction to both physician-assisted suicide and euthanasia for those who are chronically ill, from euthana-
sia for physical illness to euthanasia for psychological distress, and from voluntary euthanasia to nonvoluntary and involuntary euthanasia. [Hendin et al. 1997:1720]

University physician Carlos F. Gomez, author of *Regulating Death: Euthanasia and the Case of the Netherlands*, states about the record of euthanasia in the Netherlands:

What is becoming increasingly evident, as the bare outlines of their practice are fleshed out, is that the Dutch experience should serve as a cautionary tale, rather than a model program. What purportedly began as the ultimate exercise in patient autonomy has degenerated into the ultimate abuse in civil rights: innocent and unconsenting people are being killed, and the agents of their deaths are physicians, who are acting with the tacit consent of the courts. (Gomez 1992:6)

A final theme of frame alignment takes a middle-of-the-road approach. One medical ethicist who advocates this approach is Daniel Callahan, who sees a single moral obsession behind both medicine’s attempts to overcome mortality and attempts to solve the problem of suffering by permitting euthanasia. Each seeks compulsively to solve the problem of human existence through control. But that control is illusory, says Callahan. Everyone dies, and we all live with mortality. Hence more effort ought to be made to enhance the likelihood of a good death (Callahan 1993). Other analysts such as hospice advocate Ira Byock (Byock 1997; Wilkes 1997) and Elisabeth Kubler-Ross (Kubler-Ross 1969; 1978) add that dying presents an opportunity for family unification, fuller human realization, and other personal benefits. As de Hennezel explains: “[T]he last interval before death can also be the culmination of the shaping of a human being, even as it transforms everyone else involved. There is still time for many things to live themselves out, on a different plane, more interior and more subtle, the plane of human emotions” (de Hennezel 1997:xiv).

These arguments have come from many in the medical profession who hope to change the momentum of efforts to legalize physician-assisted suicide. They have attempted to blunt the arguments of death with dignity reformers by calling for better training in pain management and palliative care and better communication between physicians and patients and their families. Indeed, many practitioners, including the president of the AMA, have admitted that assisted suicide reform has been a wake-up call to the medical profession to do a better job.
Moreover, say proponents of the middle-of-the-road approach, legalizing physician-assisted suicide would actually hinder alternatives such as better pain care and hospice. Economic interests could lead health care providers to make suicide more available than long-term palliative care. There is some evidence that this has occurred in the Netherlands, where hospice has remained relatively rare.

These arguments are summed up well by a writer for Christianity Today, who said:

Instead of seeking legal protection for euthanasia, we would do better as a society to develop our present resources. The hospice movement, for example, needs volunteers, money, and facilities to provide a less costly and more caring context for dying. And there is room for better use of our present knowledge in managing and eliminating pain. If we put our energies into these approaches, we may discover once again that we are all connected and that agony can have meaning. (Neff 1991)

In summary, these descriptions of frame alignment depict proponents and opponents actively debating the question of whether physician-assisted suicide should get legal protection. Proponents of legal reform have sought to capitalize mostly on previously proclaimed commitments to “freedom of choice” and the “right to self-determination.” By contrast, opponents have persisted that assisted suicide would eventually worsen the problem of medicalized dying by reproducing societal discrimination. The formation of links such as these has facilitated frame alignment insofar as each side has invoked and employed select ideologies to justify its own position along preferred lines. Each side has attempted to keep the debate firmly situated in, and hopefully bound by, a set of values and discursive themes contained in the larger sociopolitical milieu.

CONCLUSION: CONTESTING THE LEGAL TREATMENT OF DYING

As this chapter has shown, during the last half of this century the war on death and disease gained momentum, and we entered the age of delayed degenerative diseases. Pain, suffering, and drug stupor became major side effects of medicalized death. Patients who valued quality of life more than just quantity of life began to demand the right to say no to modern medicine. Doctors who wanted to help lamented that their hands were tied by the law and professional ethics. A few doctors went public with the claim that legal change was needed, and soon the subject of better dying had a firm place in public, legal, and medical discourse and on reform agendas.