Spring 4-15-2019

Good and Bad Deaths: How Coalitions Transformed Framing Processes in the Movement for Physician Assisted Suicide

Keith D. Wilkins
University of New Mexico - Main Campus

Recommended Citation

Wilkins, Keith D.. "Good and Bad Deaths: How Coalitions Transformed Framing Processes in the Movement for Physician Assisted Suicide." (2019). https://digitalrepository.unm.edu/soc_etds/82

Keith D. Wilkins
Candidate

Sociology
Department

This thesis is approved, and it is acceptable in quality and form for publication:

Approved by the Thesis Committee:

Dr. Owen Whooley , Chairperson

Dr. Sharon Erickson Nepstad

Dr. Elizabeth Korver-Glenn

GOOD AND BAD DEATHS: HOW COALITIONS TRANSFORMED FRAMING PROCESSES IN THE MOVEMENT FOR PHYSICIAN ASSISTED SUICIDE

by

KEITH D. WILKINS

B.A., SOCIOLOGY, UNIVERSITY OF NEW MEXICO, 2013
B.A., CHEMISTRY, UNIVERSITY OF NEW MEXICO, 2013

THESIS

Submitted in Partial Fulfillment of the
Requirements for the Degree of

Master of Arts
Sociology

The University of New Mexico
Albuquerque, New Mexico

May 2019

ACKNOWLEDGEMENTS

I would like to heartily thank Dr. Owen Whooley, Dr. Sharon Erickson Nepstad, and Dr. Elizabeth Korver-Glenn for their critical feedback and enduring support for this research project. Another special thanks to Christian D. Brendel for writing a tailor-made macro which automatically collected hundreds of media releases and saved me many tedious hours downloading them one by one.

Keith D. Wilkins is a Ph.D. student in the Department of Sociology at the University of New Mexico. He can be contacted by e-mail at kwilkins1@unm.edu.

GOOD AND BAD DEATHS: HOW COALITIONS TRANSFORMED FRAMING PROCESSES IN THE MOVEMENT FOR PHYSICIAN ASSISTED SUICIDE

By

Keith D. Wilkins

B.A., Sociology, University of New Mexico, 2013

B.A., Chemistry, University of New Mexico, 2013

M.A. Sociology, University of New Mexico, 2019

ABSTRACT

Research on physician assisted suicide (PAS) has largely been neglected by sociological scholarship which has focused primarily on how demographic features affect support of this contentious issue. PAS represents a unique case to contribute to sociological knowledge on coalitions and framing, which has yet to fully understand how movement frames change over time and what factors makes coalition activity worth the effort. The current study addresses these gaps in the literature by studying how activist organizations that support (right-to-die) or resist (right-to-life) PAS, frame the issue. Specifically, this study aims to answer two research questions: (1) How do PAS social movement organizations appeal to medical and civil rights frames over time to depict 'good' and 'bad' deaths, and (2) How do PAS social movement organizations framing of good and bad death influence coalition activity? These questions are explored by conducting content analyses of two-hundred randomly selected media releases from right-to-life and right-to-die organizations from 1995-2018, in six U.S. states that have legalized PAS.

This research finds that right-to-die movement frames have radically shifted away from emphasizing PAS as a civil right, to representing PAS as a medical option fully compatible with existing medical standards. Framing shifts were encouraged by a critical external event that offered protection for PAS as a medical treatment. I argue that transformations in framing facilitated key right-to-die medical coalitions. The right-to-die movement's subsequent framing of death and dying has increasingly focused on traditional medical treatment options and the existential benefits of PAS. As a negative case to the right-to-die movement, right-to-life frames have remained centered on a disability rights interest and have eschewed coalition opportunities that might threaten the stability of movement frames.

Table of Contents

I. Introduction

Physician Assisted Suicide (PAS) has quickly transformed from a stalled and fringe initiative into a legitimate and successful social movement. After Oregon legalized PAS under the Death With Dignity Act (DWDA) in 1994, it took 15 years before the next U.S. state legalized their own versions of the law. But once Washington legalized PAS in 2009, Vermont followed suit in 2013, and then three more states by 2017 (see Table B in the Appendix). And between 1994 and 2005, the major right-to-die organizations would reform themselves multiple times, with one organization lasting just a year before it finally reorganized itself for the last time as the more successful and leading right-to-die group, Compassion & Choices. The evolution of right-to-die organizations over this 15-year period suggests that PAS activists have struggled to settle on consistent framing strategies. The names of organizations like The Hemlock Society and Final Exit Network, in contrast to today's leading right-to-die organization, Compassion & Choices, reflect the surprisingly divergent framing tactics right-to-die groups have prioritized over the years—on one side, suicide is boldly emphasized, while on the other a sense of empathy and control.

And in opposing the right-to-die cause, several disability rights and faith-based organizations emerged to resist pro-PAS legislation. Not Dead Yet! and Second Thoughts, two leading disability rights organizations, were formed as direct responses to the passage of pro-PAS legislation in Oregon and Massachusetts. These and three other key right-to-life organizations have been very successful in preventing PAS legislation from passing in Oregon and throughout the U.S. For twelve years following the passage of Oregon's DWDA, its legitimacy remained tentative after a permanent injunction of the law in 1995. And although it was reinstated in 1999, it was subject to a second injunction in 2001 by the U.S. attorney general.

But in 2006, the U.S. Supreme Court upheld the Oregon DWDA deciding that medical doctors and their state affiliations trumped the authority of the attorney general when it came to prescribing medications for sanctioned medical treatments. The Supreme Court ruling served as a key inflection point for the right-to-die movement which was effectively losing the battle for legalizing PAS in the late 1990s and early 2000s. The judicial decision presented an opportunity for right-to-die organizations to innovate new ways of framing PAS for the public. Specifically, the Supreme Court ruling established a unique protection for PAS that encouraged right-to-die organizations to begin building stronger and broader relationships with medical organizations and healthcare professionals.

The study of right-to-die and right-to-life social movements therefore offers a unique opportunity to better understand social movement framing dynamics and coalition building as they change over time. Specifically, this case allows me to examine how movements reconstruct frames in response to critical external events, and which in turn facilitate new opportunities to forge partnerships and coalitions with external groups whose goals had not been aligned under earlier movement frames. Further, the two sides of this debate— right-to-die and right-to-life— represent contrasting positive and negative cases (respectively) for studying framing dynamics. The data I present suggest that right-to-die organizations have substantially altered the way they frame PAS, while right-to-life groups have maintained the same frames they initially used in the 1990s. My research therefore offers insight into why some social movements may respond to external events and eventually build coalitions, while others do not.

Ultimately, this paper aims to better understand two key research questions through a content analysis of 200 randomly selected media releases from seven right-to-die and right-to-life organizations:

(1) How do right-to-life and right-to-die organizations appeal to medical frames over time to depict ‘good’ and ‘bad’ deaths?
(2) How has right-to-life and right-to-die organizations’ framing of good and bad deaths influenced coalition activity?

In answering these questions, I show that a dramatic shift in framing has occurred in right-to-die media releases which are manifested through their changing ascriptions of death and dying as ‘good’ or ‘bad’, and conversely, that right-to-life organizations have *not* substantially changed their framing of death and dying. I also show that coalition activity with external organizations occurred when right-to-die groups modified existing frames in the course of external events, and that coalitions did ***not*** occur for right-to-life groups whose frames remained centered around a disability rights identity. I argue that coalition building with external organizations is a consequence of key shifts in right-to-die framing that progressively medicalized portrayals of death and dying and was encouraged by a key external event. For right-to-life groups, I argue that a disability rights identity has deeply guided their framing of PAS and led to the rejection of new coalition opportunities.

The rest of this paper is organized to articulate the arguments above. Firstly, I provide a brief historical context of right-to-die and right-to-life organizations by detailing the actors involved, their unique organizational developments, and what their social and political interests are. Secondly, I address the location of this topic in the social movement and medical sociology literatures. I then layout this study’s methodology and the tools used to facilitate analysis. Finally, I conclude this paper with a discussion of the results and the implications for future research.

II. A Brief History of Right-to-Die and Right-to-Live

Beginnings of the Right-to-Die Movement

Political and social movements for legalizing suicide have persisted throughout American history extending as far back as the mid-1800s, but which have consistently lacked any broad legal or public support. The late 1980s and early 1990s were marked by several failed ballot measures in California, Michigan, Maine and Washington[1], all of which aimed to legalize PAS. But on November 8th, 1994 Oregon voters passed Ballot Measure 16, the Death With Dignity Act (DWDA), by a 51 to 49 percent margin representing the first successful PAS legislative effort in U.S. history. The win was short lived though, as the newly instituted law was effectively frozen. The legality of Oregon's DWDA was immediately embroiled in persistent court battles- first under a temporary injunction in 1994 and then a permanent injunction in 1995.

In 1997 though, the injunction against the DWDA was lifted by the U.S. Court of Appeals for the Ninth Circuit. Opponents of the DWDA then appealed that decision to the U.S. Supreme Court, which ultimately refused to hear their appeal leaving Oregon's DWDA intact. Despite the failure of right-to-life groups to maintain the injunction against the DWDA, in the summer following its reinstatement opponents successfully lobbied for a special election to send the law back to Oregon voters for a second time under Ballot Measure 51, a repeal of the Oregon DWDA. Sent out in November of 1997, the repeal of Oregon's DWDA was overwhelmingly defeated and in March of 1998, four years after its passage, the DWDA was used for the first time.

---

[1] For California (Proposition 161-November 3rd, 1992); Michigan (Proposal B- November 3rd, 1998); Maine (Question 1- November 7th, 2000); Washington (Initiative 119 – November 5th, 1991)

But a second and conclusive lawsuit (*Gonzales v. Oregon)* in 2003 did finally climb its way up the judicial ladder to the U.S. Supreme Court. And in 2006, the Supreme Court decided in favor of Oregon's DWDA and effectively ended any further legal challenge to the PAS law. The right-to-die success shepherded the way for Washington to follow Oregon as the second U.S. state to pass their own version of the DWDA in 2008. And within eight years of Washington's legislation four more states legalized PAS: Montana (2009), Vermont (2013), California (2015) and Colorado (2016). With the exception of Montana, whose state courts concluded that physicians who aid patient requests to die are protected under state constitution, every state (Vermont, California and Colorado) modeled their own PAS laws after Oregon's DWDA. And Washington D.C. and Hawaii have also recently legalized PAS, solidifying the continuing importance of this topic (see Table B in Appendix).

The steady succession of PAS legislation has been spearheaded by several organizations that have acted in direct contest with one another. Today, seven organizations have positioned themselves at the forefront of PAS legislation and legal battles: Compassion & Choices, the Death With Dignity National Center, Not Dead Yet, Americans Disabled Attendant Programs Today (ADAPT), the Disability Rights Education & Defense Fund, the Patients Rights Council and Second Thoughts. While other organizations have played crucial roles on both sides of this debate, the seven above have provided the largest financial and organizing contributions to political action and the most consistent media releases on PAS political activities. For example, ADAPT and NDY have become well-known as organizing arms of the disability rights and anti-PAS movements (CBS NY 2019; Weil 2013). Conversely, Compassion & Choices has provided substantial legal support to cases that sustain PAS, often submitting court dockets in their name.

In Colorado alone, Compassion & Choices provided nearly four-million dollars toward organizing efforts to legalize PAS (Brown 2016).

Right-to-Die Organizations

While proponents of right-to-die legislation argue that euthanasia and PAS are markedly different, they do have relatively similar philosophies: namely, that certain conditions are undignified and worse than death. Despite right-to-die insistence that suicide is separate from PAS, the leading right-to-die organization that championed Oregon's DWDA was The Hemlock Society and used as its moniker the poisonous drink that Socrates was given to kill himself (Plato 427-343BC). The death of Socrates represents an important type of suicide- Socrates was sentenced to death by his fellow Athenian citizens for what they deemed as the moral corruption of society and was forced kill himself with poisonous hemlock. When Socrates had the opportunity to flee Athens and avoid execution, he remained committed to what he considered his moral duty and legal responsibility as a true citizen of Athens. Socrates' final act was one of choice and especially, of human dignity. This distinction between choosing suicide or choosing to live in undignified circumstances remained a prominent theme for the early framing efforts of PAS advocates.

Eventually though, the Hemlock Society was recast nearly twenty-three years after its formation in 1980, when it reorganized itself into *End of Life Choices* in 2003. Just one year later, End of Life Choices merged in 2005 with another right-to-die organization, *Compassion in Dying*, leading to the more enduring *Compassion & Choices*. According to the organizations that split away from Compassion & Choices, these mergers and reformations were the result of internal divisions stemming from disagreements over strategies to legalize PAS. The partitions spurred more radical members to establish what is today called *Final Exit Network*, an organization founded by the head of what had been The Hemlock Society – Derek Humphry. Humphry remains a controversial figure in the assisted suicide debate and is well covered by the news media (Reinhold 1990; Abrams 1991).

As founder of The Hemlock Society and End of Life Choices, Humphry was essential in guiding activism for both organizations. And according to Final Exit Network, right-to-die organizational splits and mergers were the result of a critical PR issue- the hemlock plant that remains vividly associated with the story of Socrates, really symbolizes a voluntary form of *destructive suicide*. The Hemlock Society's slogan for 23 years was 'A Good Life, and a Good Death.' In following through with their original mission, today Final Exit Network recognizes "the need *NOW* for compassionate support and death with dignity education in all states" and "does not concern itself with politics, leaving that to experienced groups like Death With Dignity National Center and Compassion and Choices" (Final Exit Network 2019). As the more radical wing of the right-to-die movement, for those seeking 'self-deliverance' they provide information and 'services' through 'Exit Guides,' despite illegality. Making a significant departure from other right-to-die organizations, Final Exit Network still emphasizes its willingness to assist people who are not terminally-ill. For example, their organization also 'guides' those with Parkinson's disease, Alzheimer's, AIDS, muscular dystrophy, emphysema, disabling stroke, etc. And Final Exit Network's most recent news coverage describes the organization's conviction in a Minnesota district court for assisting suicide and interfering with the scene of a crime (Majchrowicz 2016). In the years following the internal split of the right-to-die movement, Final Exit Network has largely abandoned any concern for cultivating public appeal or finding allies among the medical establishment, leaving Compassion & Choices and the Death With Dignity

National Center as the primary organizations that lead pro-PAS legislative efforts across the country.

The second major right-to-die organization promoting PAS legislation is the Death With Dignity National Center. Founded in 1995 as the *Death With Dignity Legal Defense and Education Center*, the organization shortened its name in 2003 to *Oregon Death With Dignity*, and one year later merged with a California based organization, *Death With Dignity National Center,* adopting that name, dissolving its chapter in California, and ultimately headquartering in Portland, Oregon. This organization was instrumental in the legal defense of the Oregon Death With Dignity Act when it was enjoined from 2001-2006, submitting court dockets and providing legal resources that proved successful. The right-to-die group has similarly provided assistance to other state-level organizations in Vermont, California and Washington- all of which have passed PAS legislation successfully. Together, Compassion & Choices and the Death With Dignity National Center represent the primary right-to-die organizations in the U.S.

Emergence of Right-to-Life Opposition

Opposition to PAS initially started with religious-right organizations, primarily consisting of the Catholic Church and the National Right to Life Committee. The temporary and permanent injunctions against Oregon's DWDA in 1993 and 1995 (*Lee v. Oregon*) were submitted in part by the general counsel for the National Right to Life Committee, James Bopp Jr., who served on behalf of some of the plaintiffs (Hillyard and Dombrink 2001:121; Biskupic 1997). However, by 1996 the disability rights organization, Not Dead Yet (NDY), had formed as a direct result of Oregon passage of the DWDA. NDY articulated a position against suicide that is characteristic of most anti-PAS arguments- that is, opposition to medical and societal paternalism (Scaccia 2010). They argue that the medical establishment should not have the power to judge the value of a life and caution the public against legalizing PAS to prevent dangerous slippery-slope scenarios. Considering this point to be a fundamental difference between right-to-die and right-to-life moral values, Not Dead Yet (NDY) has sustained broad countermovement activity across the U.S. and particularly in Oregon, Washington, California, Vermont, Colorado, and Washington D.C.

NDY's partners in activism include four other right-to-life organizations. One of them, Americans Disabled Attendant Programs Today (ADAPT), has contested PAS legislation across the U.S. and has deeper political roots stemming from their 1970s advocacy for the transportation rights of persons with disabilities (Shapiro 1994:330). ADAPT's most recent efforts have aimed at preventing the legalization of PAS under the Americans with Disabilities Act (ADA) in Washington, D.C., but their coalition efforts with NDY have taken place in Vermont, California, and Colorado. And under the general guidance of NDY and ADAPT, two other right-to-life organizations have emerged in more recent battleground states: Second Thoughts and the Disability Rights Education & Defense Fund (DREDF). Like ADAPT, DREDF has been involved in disability rights activism since 1979 (DREDF 2019) and over the past 14 years has partnered with NDY and ADAPT multiple times (DREDF 2005). Similarly, the right-to-life group, Second Thoughts, formed in 2012 with the direct help and support of both NDY and DREDF to resist right-to-die legislation and extensively covers right-to-life political activity. And lastly, the Patients Rights Council has provided consistent resistance to right-to-die organizations for over 32 years. Organized in 1987 as the *International Anti-Euthanasia Task Force*, they eventually reformed as the *International Task Force on Euthanasia and Assisted Suicide*, and today are known as the *Patients Rights Council*. They have been active participants in critical legal battles involving PAS legislation since Oregon's DWDA (Hillyard and

Dombrink 2001: 260). In all, five major right-to-life organizations have taken the lead in resisting right-to-die efforts in the U.S: Not Dead Yet, Americans Disabled Attendant Programs Today, Second Thoughts, the Disability Rights Education & Defense Fund and the Patients Rights Council.

Medical Organizations

In addition to the right-to-die and right-to-life organizations, physicians and medical interest groups have emerged as key figures of authority in the PAS debate. But official surveys within the medical community indicate that physicians are divided in their support for PAS legislation. By some estimates, nearly *half* of all physicians disagree with or would be unwilling to provide life-ending treatment should it be requested. What's more, other surveys find that the *majority* of physicians would be unwilling to provide such services even if they were legalized (Craig et al. 2007; Lee et al. 1996; Cohen et al. 1994). And yet, as of December 2, 2017, physician organizations like the Massachusetts Medical Society (MMS) overturned their previously held opposition on PAS in response to increasing physician support for the practice. The resulting policy decision opted-out of the PAS debate and instead favored physicians' neutrality on the issue. With the exception of Washington state, the largest medical associations in Oregon, California, Vermont, Colorado and Washington D.C. have adopted neutral stances with similar justifications to the Massachusetts Medical Society.

Because physicians are the only ones who can prescribe fatal medications through death with dignity legislation, they are the true gatekeepers that any request for PAS must pass through. The framing that right-to-die organizations must appeal to is therefore two-fold: it attempts to convince the voters who ultimately pass legislation, as well as the medical community who must be complicit in prescribing lethal medications. Medical associations' neutral stances have therefore made it possible for right-to-die groups to engage medical and lay audiences in conversations about the role of PAS in death and dying, especially in contexts where science and medicine fail to offer the certainty of a painless death. However, medical organizations continue to remain (at least publicly) steadfastly brief about PAS. And a preliminary exploration I conducted of medical association's press releases covering PAS only captured terse descriptions of their official positions—namely, that of neutrality or prohibition. For this reason, medical associations were not included in the analysis.

Key Organizations

In summary, the PAS movement has developed into a contentious social issue with seven key right-to-die and right-to-life organizations establishing a dominant public and political presence in five states – Washington, Vermont, California, Colorado and Washington D.C. Two enduring organizations make up the right-to-die movement: Compassion & Choices and the Death with Dignity National Center. And five organizations have guided the oppositely positioned right-to-life movement: Not Dead Yet (NDY), American Disabled Attendant Programs Today(ADAPT), Second Thoughts, the Patients Rights Council, and the Disability Rights Education & Defense Fund (DREDF). This paper aims to better understand how these key organizations have distinguished PAS as good or bad over time, and how building relationships with external organizations has been affected by changing social movement frames. In exploring how these key organizations' frames have changed over time, two areas of scholarship are critical to my analysis: (1) scholarship which investigates the role coalition activity has on social movement frames and (2) scholarship on how the institution of medicine affects public understandings of death and dying.

III. Social Movement and Medical Sociology Literature

Framing

The process of framing has been studied by social movement scholars who have described it as the "struggle over the production of mobilizing and countermobilizing ideas and meaning" (Snow and Benford 2000: 613) surrounding political events, the use of objects, or other social problems more broadly. The aim of this appropriation over meaning is to "mobilize potential adherents and constituents, to garner bystander support, and to demobilize antagonists" (Snow and Benford 1988: 198). Ideally, these frames resonate with target audiences and convince them that a particular perspective on a social issue is worthy or just. Benford and Snow (1988) have outlined three framing processes that are essential for mobilizing potential activists: (1) that organizations *diagnose* social problems which require action from potential activists, (2) that *plans of action* be drafted which 'cure' the essential issue, (prognostic framing) and (3) a general *call to arms* that prepares social movement members to correct the social problem (motivational framing).

In the case of the right-to-die movement, mobilization frames have presented new diagnostic frameworks of terminal illness that are generally congruent with medical principles and ethics. For example, one of the frames that PAS advocates build-up emphasizes the reduction of patient *suffering.* Such tactics have similarly been described by social movement scholars as frame-amplification, which situate "…mobilization appeals in the language of cherished [medical] principles" (Snow et al. 1986:469). Similarly, 'motivational framing' strategies encourage activists to participate by mustering "vocabularies of severity, urgency, efficacy and propriety" (Benford and Snow 2000:617). Lastly, Snow and Benford (1988:208) have also identified a series of constraints for frames that speak to whether they will resonate with participants: (1) what they term ‘empirical credibility’, (2) experiential commensurability, and (3) narrative fidelity. Together, these constraints suggest that the effectiveness of frames are bound to their everyday relatability with an issue and/or its proposed solutions, as well as to the degree with which frames have coherence with prevailing cultural ideologies.

But while research has explored the theoretical underpinnings of how frames mobilize participants, it has not widely explored how coalitions with external organizations are influenced by social movement frames. Each organization can have a unique frame for mobilizing activists and it remains unclear how the merging or partnering of organizations consolidate their separate frames with one other, or how frames change over time. Do movements hybridize their frames in equal transactions? Or do certain frames win out more than others? And particularly, what factors might be involved in the rejection of old or new frames? Two studies in particular illuminate aspects of this unexplored area.

Coalitions and Framing

Again, very little research has investigated the role of coalitions in shaping social movement frames. But one study by Andre Magnan (2008) performed a content analysis of key documents, newspaper articles and media statements related to coalitions made by groups of farmers contesting the introduction of genetically modified (GM) wheat. Megnan focused on how frame coherence is achieved among diverse organizational interests. Theoretically, this work is informed by a neo-Gramscian approach to counter-hegemonic processes and how those contesting hegemonic ideologies achieve success with contentious frames. The author concluded that frames among allied anti-GM wheat organizations encouraged ‘lowest common denominator’ frames, whereby the original movement frames were ‘distilled’ into simpler ones as social movements combined forces. In this way, more complex and broader appealing frames were difficult to achieve as groups bonded together. And particularly, the organizations which banded together were ultimately unable to effectively challenge the more systemic agrofood relations involved in the GM wheat debate.

Another critical study by Marc Dixon and Andrew W. Martin (2012) measured the impact that external allies and political threat had on unionization activity. Their analysis sifted through newspaper and media coverage of union strikes and determined that coalition efforts among union organizations were common, but that they did not form coalitions *outside* of their internal union-firm networks. Additionally, the perception of threat was crucial for whether unions formed coalitions. Surprisingly, it was the more immediate threats to political success that were correlated with *less* coalition activity. The authors further concluded that they were unable to address a critical feature of coalition work: what makes the mobilization of external allies "worth the effort" (Dixon and Martin 2012: 964)?

Ultimately, research on coalitions and framing has uncovered important processes regarding social movement success and frame consolidation. But research has yet to understand how those framing processes are influenced by coalitions that do not contest hegemonic political and cultural understandings, and instead work to absorb the essential ideological components of hegemonic frames. Scholarship also has yet to fully understand what factors are involved in making coalitions or their resultant frames 'worth the effort.' Research suggests that when coalitions form, the resulting frames reduce to a set of shared ideologies. But in cases where organizations share very little ideological similarities, like when right-to-die organizations form coalitions with medical ethics groups, do frames still reflect a lowest common denominator? And more critically, how are coherent frames achieved when coalitions are made between organizations that maintain opposing ideologies?

Medical Sociology

Research from medical sociology has somewhat unevenly investigated PAS in three ways: (1) by studying the right-to-die movement only as it emerged in the early 2000s, (2) strictly investigating physician or public attitudes and support towards PAS, and (3) limiting social movement or political analyses to countries other than the U.S. (Karsoho et al 2016; Danyliv & O'Neil 2015; Nissim et al 2009; Onwuteaka-Philipsen et al 2000). As an important exception, Karsoho and colleagues (2016) have aimed at more broadly understanding whether right-to-die activists represented a movement toward de-medicalization and anti-hegemonic interests. Their study conducted in-depth interviews with a sample of 42 of the original litigants from *Carter v. Canada* (the key court case which made PAS legal in Canada) and explored the relationship between assisted suicide and right-to-die discourses regarding suffering, palliative care, and medicine. Karsoho et al. (2016) concluded that proponents of PAS "argue that the significance of a [PAS] regime lies beyond the legal provision of lethal medication…they emphasize what they see to be the *transformative power of physicians' involvement* in [PAS]" (195- emphasis added). That is, proponents of the right-to-die represented an opposition to the medical status quo, but not to increasing medicalization. Instead, Karsoho and colleagues determined that medicine was the emancipatory medium for right-to-die activists.

What remained unexplored in Karsoho et al.'s study though, was whether right-to-die proponents have always held medicalizing perspectives, and how right-to-die proponents have articulated those perspectives in response to success and failure. The authors also recognized that their contribution was primarily situated in key right-to-die proponents' construction of end of life suffering within medicine (Karsoho et al. 2016:194). Therefore, a gap still remains in the literature regarding how PAS, medicine, and key concepts of death and dying are constructed by right-to-die organizations (not just key figures in the debate) in contexts outside of the Canadian justice system.

As a last notable exception in the medical sociology scholarship, Daniel Hillyard and John Dombrink (2001) have written a comprehensive account of the right-to-die movement in their book, *Dying Right.* Their catalogue of the movement begins with the passage of Oregon's DWDA in 1994 and ends just before the U.S. attorney general enjoined it for the second time in 2001. Their account ultimately ends with the unique moralized depictions of death which are characteristic of the PAS debate (e.g. good death and bad death). But their discussion spans only four pages and falls short of illustrating what those moral constructions of death and dying are, and what their significance is to the broader institution of medicine. And while they consider at length the early prominence of religious organizations that battled against Oregon's DWDA, they do not fully capture what would be the eventual rise and influence of disability rights groups within the PAS debate. For this reason, *Dying Right* exceptionally explores the political battle of right-to-die and right-to-life organizations, yet leaves unresolved the role of medicine in the PAS movement's framing of death and dying.

As right-to-die advocates have succeeded in passing pro-PAS legislation in recent years, they have increasingly referred to their medical coalitions. Conversely, right-to-life advocates have continued to denounce medical interpretations of a life worth living. And yet, physician assisted suicide (PAS) remains widely unexplored by medical sociology. Specifically, it remains unclear how right-to-die and right-to-life groups in the U.S. context have articulated medicine's role in death and dying through PAS, and how depictions of good and bad deaths can represent countervailing or sustaining forces in medicalization.

IV. Methodology

Data and Sampling

This study contributes to sociological knowledge by primarily performing content analyses of media releases for seven major PAS organizations: Compassion & Choices, the Death With Dignity National Center, Not Dead Yet, Americans Disabled Attendant Programs Today, Second Thoughts, the Disability Rights Education & Defense Fund and the Patients Rights Council. Right-to-die and right-to-life media releases were downloaded from each organizations' websites and stored in Microsoft Word documents. Selection of media releases were also constrained to five U.S. states: Washington, Vermont, California, Colorado and Washington D.C. Media releases were limited to these five states because they represent the most recent state governments to legalize PAS, and where right-to-die coalitions have emerged. As a result, these five states narrow the analytical lens which captures framing dynamics and coalition activity in right-to-die organizations from 2005-2017[2]. Media releases for right-to-life organizations were also constrained to these states. Altogether, the total set of media releases before random sampling included 683 documents.

To establish a reliable comparison for changes in framing that have occurred in the 2005-2017 post-coalition period, I have also included documentation that captures the pre-coalition right-to-die period: five essays on physician assisted suicide written by Derek Humphry from 1995 to 2007. This set of pre-coalition material were obtained from Derek Humphry's personal

---

[2] As described earlier, Compassion & Choices is the organizational merging of End-of-Life Choices, and Compassion in Dying in 2005. The Death With Dignity National Center is also the merging of two organizations in 2003: Death With Dignity Legal Defense and Education Center, and Oregon Death With Dignity. These two groups have worked together, both monetarily and organizationally, to defend and promote right-to-die efforts since their consolidations. Similarly, Not Dead Yet, Second Thoughts, the Patients Rights Council and Disability Rights Education & Defense Fund have organized activism together, often referring to each other's blogs and protest activity.

website, FinalExit.org. And alongside these pre-coalition right-to-die documents, seven randomly selected media releases by three right-to-life organizations (Not Dead Yet, Patients Rights Council, and the Disability Rights and Education Fund) between 1995 and 2007 were used to establish a pre-coalition right-to-life period.

Sampling proceeded by arranging the total set of post-coalition right-to-die and right-to-life documents for each group across five U.S. states (WA, VT, CA, CO, D.C.) in chronological order using Microsoft Excel. Documents were then assigned sequential values beginning with ‘1’, based on their chronological order. One-hundred media releases for each group, right-to-die and right-to-life, were then randomly selected for analysis using a sequential random number generator (https://www.random.org/sequences/). Those selected documents were then imported into NVivo 12. In total, 200 media releases were analyzed across both groups.

Data Analysis

Coding was carried out by first reading a media release and then coding all relevant themes that were critical to the framing of PAS. The first round of coding yielded 122 unique categories and themes. At this point, coding schemes were either simplified by collapsing similar and related categories, or split in cases where themes were highly prevalent. In alignment with the research questions, particular attention was placed on uncovering themes related to coalition work and portrayals of death and dying as good or bad. Afterward, a second round of coding was completed to ensure the accuracy of previous coding schemes and to capture any themes that may have been missed in the first round of coding. After the second round of coding, all coding schemes were ultimately consolidated into 30 unique categories which were critical to understanding how right-to-life and right-to-die organizations have framed PAS over time.

I have described earlier that my research questions aim to better understand how right-to-die and right-to-life organizations present death and dying through moralized frames (e.g. a good death, a bad death). In light of this, Hilgartner's theoretical framework for analyzing documents with attention to their performative and persuasive presentations of self is both appropriate and useful. Such an analysis "explores how the protagonists in these theatrical contests work to create persuasive performances, exploring the art and artifice they employ to foster impressions and shape the experience of their audiences" (Hilgartner 2000: 9) This necessarily involved coding right-to-life and right-to-die media releases for depictions of 'Good Deaths' and 'Bad Deaths'. Coding schemes then sought to uncover whether pre- and post-coalitions distinguished what constituted good and bad deaths. Similarly, the formation of coalitions and their effect(s) on framing were given specific attention during coding. For example, this included categorizing the 'theater' of coalition work which included categorizing the types of external organizations that were discussed in media releases (religious, political, medical, etc.), the actors involved (family, patient, doctor, etc.) and where they took place (states, institutions, hospitals, courts etc.).

Coding categories also successively reflected emergent themes and rhetoric throughout the coding process. Some scholars have described this kind of research process as Grounded Theory (Glaser and Strauss 1967; Charmaz 2000). However, I subscribe to an orientation offered by Timmermans and Tavory (2012) called abductive analysis. Abductive analysis is a research process that first involves making "a preliminary guess based on the interplay between existing theories and data when anomalies or unexpected findings occur" (179). The researcher then compares these findings to existing theories and either verifies existing theories, or builds new ones based on an "inductive conceptualization of this data through intensive coding." In addition to Hilgartner's framework, abductive analysis has also guided data analysis.

V. Results

In the course of coding media releases, I achieved thematic saturation[3] for two distinct periods in the right-to-die movement. Key coalition activity also emerged for medial releases in those periods and reflected the unique shifts in how right-to-die organizations depicted the relationship between PAS, medicine, and individuals. These coalition events are noted in the appended Table A. Right-to-die frames between these periods shifted in two significant ways: (1) they increasingly incorporated medical personnel on issues of death and dying, and (2) diminished the life and death stakes surrounding PAS. I explore these transformations by dividing the right-to-die movement into two periods: pre-coalition and post-coalition. Between each I describe a critical external event, *Gonzales v. Oregon*, which I argue spurred right-to-die framing shifts that occurred afterward. I then follow-up with a discussion of right-to-life frames, elaborating on the stability of how these groups characterize PAS, and provide an explanation for why right-to-life groups have rejected opportunities for coalition work.

Pre-Coalition Period

Rational Suicide

The right-to-die pre-coalition period was characterized by a set of two persistent frames: an emphasis on individual rationalism, and a broader insistence on any individual's liberty and freedom to choose suicide. Media releases in the pre-coalition period established the need for people to act on rational choices and exercise their personal autonomy in deciding what counted

---

[3] Mario Small (2009) has described saturation as a descriptive for when qualitative data, despite not representing a true random sample, achieves an analytically meaningful stability from the sample—at this point data begins to reflect theoretical replication and no new unique information is gleaned from subsequent cases. In my case, saturation meant that media releases revealed no new themes (e.g. Rational suicide, freedom to die, choice and suicide, etc.) from prior ones and were predictive of what themes emerged in the media releases that followed.

as a ‘quality life’. A 1995 release is emblematic and details how the ‘Question of Character’ relates to PAS. In it, Derek Humphry—founder of The Hemlock Society—describes the specific factors that influenced his decision to assist his late wife’s (Jean Humphry) suicide:

> “…the clinching consideration is whether or not the person desiring an accelerated death, or the one asked to help, feels instinctively that it is right for them. This 'rightness' is based on a multitude of influences, the most important being the person's life experience…when Jean, my first wife, asked me to help her to die it came as a surprise since we had never previously discussed the matter. It did not strike me as a shocking option in view of her condition and nature. In fact, it seemed most sensible. She had bone cancer, with secondaries, and her strong character always had demonstrated an ability to think things through calmly and to make decisions right for her.” (1995)

Tellingly, the release is titled “Who Will Help Another to Die?” and further on identifies three critical features of those who desire “self-deliverance”: (1) Loss of hope for a medical cure, (2) A strictly personal desire to die, sans psychological illness, and (3) A specific plan for how death should be carried out. The features he outlines highlight how right-to-die groups originally conceived of PAS—An organized, rational decision and especially distinct from other *irrational* forms of suicide (e.g. mental illness).

The emphasis on rational suicide was strikingly persistent in the pre-coalition period. Another example from a 1996 media release highlighted the *loss of control* in modern society and argued that PAS was a necessary right in order to regain that control:

> “While it is true that we have no control over our births, *at least we ought to have control over our deaths*. How can we claim to be free people if someone else's morals and standards govern the way we die?...We die differently today from our forebears. In this century, medicine has made tremendous strides towards keeping us healthy and living longer, for which we are all grateful. But modern medicine has not entirely solved the problem of terminal pain, and it certainly never will be able to answer *the very personal question of an individual person's quality of life*” (1996-Emphasis added).

And right-to-die media releases portrayed the consequences of a world without PAS by constructing abstract scenes of death and dying. These scenes accordingly employed rational actors and intimately personal judgments in determining what counted as tolerable living conditions:

> “I believe that there is a second form of suicide -- justifiable suicide, which is rational and planned deliverance from a painful and hopeless disease. I don't think the word 'suicide' sits too well in this context but we are stuck with it. I have struggled for twenty years to popularize the term 'self-deliverance'…” (2000)
>
> “Whereas modern medicine has brought great benefits to humanity, it cannot entirely solve the pain and distress of the dying process. Each person deals with death in their individual way. Which way is determined by their health, their ethics, and personal living conditions. The degree to which physical pain and psychological distress can be tolerated is different in all humans. Quality of life judgments are private and personal, thus only the sufferer can make relevant decisions.” (2007)

As the last quote highlights, good deaths for right-to-die groups depicted empowered individuals who accepted their terminal fate, especially when modern medicine was unable to cure their disease or alleviate continued suffering. Frames particularly focused on promoting the concept of ‘self-deliverance’ through PAS, promoting the notion of an honorable and noble death. Such descriptions were extremely reminiscent of Plato’s poetic description of Socrates’ death—a key inspiration for the pre-coalition right-to-die group The Hemlock Society.

Choosing Suicide

In addition to themes surrounding rational decisions, right-to-die pre-coalition frames emphasized the power of *choosing death*. These frames went beyond simply selling a logic of suicide, and instead extolled the virtue of any person to select the time, manner, and place of their death. One release exemplified this by defending the importance of empathy in understanding what PAS means for those who are dying:

> “In a spirit of compassion for all, this manifesto proclaims that every competent adult has the incontestable right to humankind’s ultimate *civil and personal liberty* -- the right to die in a manner and at a time of *their own choosing*…Each person deals with death in their individual way. Which way is determined by their health, their ethics, and personal living conditions. The degree to which physical pain and psychological distress can be

> tolerated is different in all humans. *Quality of life judgments are private and personal, thus only the sufferer can make relevant decisions*" (2007).

Choice, personal liberty and the private nature of committing suicide are the hallmarks of pre-coalition frames. Right-to-die organizations attempted to persuade readers that medicine fails those afflicted with degenerative diseases and justified suicide for *any* rational reasons. This orientation is made all the more concerning when one media release explained that PAS was necessary for the "two percent" of people who are likely to die from more prolonged and intolerable illnesses, such as:

> "There is the scourge of AIDS, which in some cases is a terrible death. More of us die of degenerative diseases *like A.L.S. (motor neuron disease), Parkinson's, Multiple Sclerosis, Alzeheimer's Disease*[sic]*, and Osteoporosis*. These wasting diseases take years to run their course -- sometimes 10 to 15. Our grandparents knew very little of such diseases because they died earlier. Two out of every five of us is going to die from a degenerative disease." (1996)

The same release also described the 'psychic toll' of "loss of bowel control, haemorraging[sic], *permanent hiccups*" (emphasis added) that underscored the need for a personal right to choose suicide.

Good and Bad Death

But in naming specific diseases and symptoms in this pre-coalition period, right-to-die media releases constructed a particular type of death- a bad one. Bad deaths were portrayed as painful, prolonged, and medically uncertain. And in line with what many right-to-life groups have signaled profound concern about, disability also often characterized these deaths. From a media release in 2000, The Hemlock Society listed three reasons why PAS should be legalized, detailing what constituted a bad death:

> "1. Advanced terminal illness that is causing unbearable suffering - combined physical and psychic -- to the individual despite good medical care. 2. Total loss of quality of life due to protracted, incurable medical conditions. 3. *Grave physical handicap which is so restricting that the individual cannot, even after due consideration, counseling and re-*

> *training, tolerate such a limited existence… there are some disabled who would, at a certain point, rather die.*” (2000)

Right-to-die media releases also reiterated the travesty of circumstances where medicine was unable to alleviate pain except through unconsciousness and loss of self, all of which complicate common sense distinctions between life and death:

> “Fortunately most, but not all, terminal pain can today be controlled with the sophisticated use of drugs, but the point these leaders miss is that personal quality of life is vital to some people. *If one's body has been so destroyed by disease that it is not worth living, then that is an intensely individual decision which should not be thwarted. In some cases of the final days in hospice care, when the pain is very serious, the patient is drugged into unconsciousness ('terminal sedation')*. If that way is acceptable to the patient, fine. *But some people do not wish their final days to be spent in that drugged limbo.*” (2000)

Ultimately, the pre-coalition period broadly framed physicians and the medical establishment as barriers to a good death and often implied their villainy in parading false hope to those with terminal illnesses. Death itself was framed as a nexus in which medical treatment was ill-equipped to address personal suffering and ensure that patients retained their sense of self at the end of life. And in this way, right-to-die groups defined a good death as conscious, planned, painless, and de-medicalized. One of the explicit aims of the right-to-die movement in the pre-coalition period was to make PAS a civil right which would compel medical personnel to assist the suicides of those that wanted hastened death. Right-to-die groups argued that choosing death was a personal liberty that doctors should be unable to block. And prominent professional organizations like the American Medical Association (AMA) remained strongly opposed to allowing physicians any ethical leeway to practice PAS. They maintained that PAS was an unethical practice and “fundamentally incompatible with the physician’s role as healer… and would pose serious societal risks” (AMA Code of Ethics 5.7). But despite the passage of the Oregon DWDA without the help of medical groups like the AMA, PAS as a national civil right was still a distant dream by the mid-1990s. However, right-to-die groups were presented with a unique success in the mid-2000s that called into question existing right-to-die frames and offered a new pathway to success.

Gonzales v. Oregon

The years after the passage of Oregon's DWDA retained an air of uncertainty for the law's legitimacy. When it passed in November of 1994, a temporary injunction was immediately placed on the DWDA. And in 1995, the judge for the U.S District Court of Oregon, Michael Hogan, permanently enjoined it. Right-to-die groups eventually appealed Judge Hogan's decision and two years later, Oregon's DWDA was reinstated[4]. But the law was once again short-lived. In 2001, the Attorney General for the Bush Administration, John Ashcroft, argued that PAS was a fundamental violation of the Controlled Substances Act (Charatan 2006). Ashcroft argued that the use of drugs like Morphine to hasten death were not a legitimate medical practice and therefore were subject to regulation. But the Supreme Court would decide in 2006, that the intent of the Controlled Substances act was not to regulate the medical profession, but to halt drug trafficking. The court's consensus was based on an understanding that whatever constituted *legitimate* medical practices could only be determined by medical professionals, and not political appointees. When Justice Kennedy delivered the opinion of the Supreme Court, he specified *who* it was that could determine legitimate medical treatments:

> "In deciding whether the CSA can be read as prohibiting physician-assisted suicide, we look to the statute's text and design. The statute and our case law amply support the conclusion that Congress regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood. Beyond this, however, the statute manifests no intent to regulate the practice of medicine generally… For all these reasons, we conclude the CSA's prescription requirement does not authorize the Attorney General to bar

---

[4] Oregon's Death With Dignity Act was reinstated by a three judge panel in the U.S Court of Appeals, Ninth Circuit on February 27th, 1997.

> dispensing controlled substances for assisted suicide *in the face of a state medical regime permitting such conduct*."

The Supreme Court's opinion was critical to the right-to-die movement for two essential reasons. Firstly, the right-to-die movement had faced persistent opposition and legal set-backs for the 12 years leading up to the 2006 ruling. And prior to *Gonzales v. Oregon,* the Supreme Court ruled against two other PAS cases deciding that (1) there was no fundamental liberty protection for assisted suicide and (2) that state bans on assisted suicide did not violate Fourteenth Amendment rights[5]. Secondly, *Gonzales v. Oregon* represented a profound opportunity for right-to-die organizations—if they could convince 'medical regimes' to permit PAS, future legislation had been provided a fundamental protection. *Gonzales v. Oregon* was therefore a critical inflection point for the right-to-die movement, which before the Supreme Court ruling was failing under pre-coalition frames. And after this key external event, right-to-die groups transformed the way they framed PAS. Beginning with the formation of *Compassion & Choices* in the same year that oral arguments were heard in *Gonzales v. Oregon*, right-to-die groups fundamentally shifted the way they depicted the institution of medicine in death and dying.

Post-Coalition Period

Warming-Up to Medicine

The merging of *Compassion in Dying* and *End of Life Choices* in 2005 marked the first right-to-die coalition activity prior to the 2006 Supreme Court ruling. The result of the merger, *Compassion & Choices*, signaled an early attempt to transform how right-to-die groups presented

---

[5] Washington v. Glucksberg (1997) was a 9-0 Supreme Court ruling that decided no fundamental liberty to assisted suicide existed; Vacco v. Quill (1997) was another 9-0 Supreme Court ruling that decided state bans on assisted suicide were legal and did not violate Fourteenth Amendment rights.

PAS to the public[6]. The first sampled media release from the post-coalition period is representative of right-to-die frames following the 2006 Supreme Court decision. Rather than the legalistic descriptions of personal freedom that defined the pre-coalition period, frames began to portray PAS as facilitating better patient-physician relationships. The right-to-die release cited medical research published in the Journal of the American Medical Association which found that patients who discuss approaching the end of life with their doctor have increased enrollment in hospice, and less anxiety and depression than those who did not:

> "The study confirms the benefits of Death with Dignity and Right-to-Know laws…'Doctors are not always straightforward about the true prognosis and offer false hope,' said Barbara Coombs Lee, president of Compassion & Choices. 'As a result, treatments can leave patients too weak to spend quality time with loved ones, rectify relationships, or seek spiritual peace. *When patients have full information about all of their options, they are empowered to knowingly choose' or refuse 'difficult treatment.*'" (2008)

Early post-coalition media releases like the one above, also presented somewhat contradictory attitudes toward the medical establishment. On one hand, they remained critical of how physicians treated terminal patients, but they also argued that doctors were the solution, rather than a barrier, for a better death. And physician trust only *increased* over time, progressively abandoning the distrustful medical sentiment that characterized the pre-coalition period.

In establishing this right-to-die transition, an early 2010 release further illustrates how the medical system was still framed as untrustworthy at times:

> "It was clear to me, my daughter, and his niece, that he was suffering tremendously, and we were all traumatized by watching helplessly as he died a slow and agonizing death. *Not once did any Whatcom Hospice staff mention that Norman had other options, such as palliative sedation (sedation to unconsciousness until death) or aid in dying under the*

---

[6] As described earlier, movement leaders like Derek Humphry have described the split between Compassion & Choices and Final Exit Network as an unavoidable division between right-to-die activists interested in immediate action to aid those who desire PAS, and other activists who are more interested in winning the hearts and minds of the public through PR campaigns.

> *Washington Death With Dignity Act (DWDA). I learned about the DWDA the day after Norman died*." (2010)

But this negative portrayal of physicians and medical personnel stands in stark contrast to another 2010 media release that presented one doctor's explanation for why PAS was becoming increasingly popular among medical providers:

> "Dr. Preston is in a unique position to comment on Death With Dignity. As a physician, Dr. Preston understands the need for doctors to be healers, but also to end suffering for dying patients. Preston notes that more and more physicians are realizing that 'death with dignity' is a humane part of medical practice. By participating in physician aid in dying, *physicians are helping patients gain release from the agonies of extended dying. They are staying with their patients and giving good end-of-life care.*" (2010)

The virtuous physician advanced even further in another release that highlighted the political and medical success of the Washington state Death with Dignity Act:

> "Lonnie Maxfield, of Olympia, who is terminally ill with ALS (Lou Gehrig's disease), said that the DWDA provides him with peace of mind, 'I'm very grateful for our Death with Dignity Act, *and that my doctor respects my end-of-life choices…*" (2011)

And by February of 2013, the positive framing of physicians turned into outright reverence, as it defended the sanctity of the relationship between doctors and their patients. Elaborating on a bill to imprison physicians assisting suicide, the right-to-die media release extoled physicians:

> "Threatening doctors with 10 years in jail for honoring a terminally ill patient's request for aid in dying *violates the sacred doctor-patient relationship*…" (2013)

The progressive warming of the right-do-die movement toward the medical establishment indicated a clear departure from the pre-coalition period, which had made sacred the liberty and freedom of an individual to choose death. And as right-to-die frames shifted, a new kind of organizational partnership began to emerge—coalitions with medical groups.

Right to Die Medical Coalitions

In 2014, one right-to-die group made clear how they were making death with dignity a reality in the state of Vermont. They wrote:

> "So we're developing that core group of responsible doctors, nurses, pharmacists, volunteers and all the other people needed to make this practice viable in Vermont. C&C recruited Linda Waite-Simpson as the new state director…Her main role is advocacy for the law 'making sure people understand it and can access it, educating the entire state on what it means and that it's available.' *That will include reaching out broadly throughout the medical community and general public, recruiting volunteers and enlisting participating physicians and pharmacists.*" (2014)

To accomplish this 'advocacy for law', the right-to-die group elaborated on a critical pathway which information about aid-in-dying would be disseminated:

> "Bonnie and Peter Reagan, two Oregon physicians who participate in their state's law, represented Compassion & Choices when they spoke at last fall's Vermont Ethics Network's annual conference, 'Vermont's New Normal: End-of-Life Care and Physician Aid in Dying.' C&C also sponsored a booth at the event. *Most recently, Compassion & Choices staff held an informational meeting with Vermont Ethics Network and Patient Choices Vermont that detailed exactly what happens when someone calls a C&C end-of-life consultant at 800.247.7421.*" (2014)

The pathway to success was direct consultation with healthcare providers and involved right-to-die groups winning over the hearts and minds of medical professionals. The same release also cited the core mission of the Vermont Ethics Network, which was to "promote ethics as a core component of health care and health care decisions for indiviudals[sic], clinicians, health care organizations, and the larger community" (VTEthicsNetwork 2018). That mission is made all the easier if you consider that of the organization's twelve board of directors, four are M.D.s, one is a psychologist, two are R.N.s, and all of whom either practice or teach at medical schools and some do both. Right-to-die partnerships with medical groups like the Vermont Ethics Network highlight the key shift in pre- and post-coalition movement strategies—physicians became central to the success of PAS in the years after 2006. Right-to-die groups in the post-coalition period began integrating what were originally divergent frames of understanding, moving beyond stories of negligent medical staff who allowed people to needlessly suffer, and instead championed healthcare professionals as the stewards of dignity.

A newsletter published by the Vermont Ethics Network in 2013 attests to the kind of relationship right-to-die groups have developed with medical organizations. In the newsletter, not only is Compassion & Choices listed as one of the primary resources they recommend to anyone interested in learning more about Vermont Physician Aid in Dying, but they're also listed as a resource for *finding* a physician who is willing to fulfill the law. And in a presentation that was coordinated by the same right-to-die group at the Vermont Ethics Network conference, the right-to-die movement extended its influence into the realm of professional practice. Their presentation was titled "Clinical Practice Guidelines for Aid in Dying," and while the content can't be known from the media releases captured in my analysis, it does underscore the broader right-to-die effort to develop stronger ties to the medical community.

But providing clinical practice guidelines for medical professionals represented a fundamentally different tactic than had been attempted in the past. Right-to-die organizations traditionally focused on informing patients of their medical rights and lobbying legislators and assemblies to make PAS legal. And coalitions with medical organizations coincided with a rapid transformation in what PAS *signified*- it was no longer a civil right or a legislative commodity, but rather a *medical treatment* requiring technical understanding and clinical practice guidelines. Once again, right-to-die groups shifted their framing of PAS so that it no longer simply aimed at persuading healthcare providers that PAS was an essential hope for terminal patients. Rather, right-to-die organizations now suggested that PAS could be integrated into medical practice on a national scale. Two key framing shifts reinforced the possibility of PAS as a broadly legitimate medical practice: (1) an emphasis on palliative care treatments which de-prioritized PAS, and (2) an increasing emphasis on the *existential* comfort PAS provided patients as a medical option.

Palliative Care and Existential Comfort

The right-to-die shift toward palliative care is best characterized in a release titled "Nationwide Impact Grows," that references an active partnership with the California Primary Care Association[7] and which reported 'great progress' for the cause. It opened with a quote from the right-to-die group's national director of policy and programs:

> "'Our California Access Campaign will educate and empower doctors and terminally ill adults about all the end-of-life care options to relieve intolerable suffering, including hospice, palliative care and medical aid in dying.' The launch was announced during a news conference at the California Primary Care Association (CPCA) in Sacramento. *The CPCA is among a group of health centers, hospitals, hospice facilities and nonprofit organizations partnering with Compassion & Choices to ensure that all Californians know aid in dying is an available and safe end-of-life option.*" (2015)

Their partnership was also accompanied by a unique service, Doc2Doc, which established a free national telephone line for physicians treating terminally ill patients. The service would provide one-on-one consultations with right-to-die medical doctors to discuss 'end of life options'—particularly, options *other than* PAS, which is the last listed option:

> "Hospice, palliative care and effective pain and symptom management.
> How to follow current clinical practice guidelines.
> How specific state laws affect end-of-life care.
> How to communicate with patients, pharmacists and family members.
> What to expect in a patient-controlled death.
> How to handle patients' inquiries or requests concerning withdrawal of life-sustaining treatment.
> How to handle a badly suffering, terminally ill patient's request for assistance in achieving a painless, peaceful death." (2015)

---

[7] The California Primary Care Association is a statewide organization representing over 1,300 medical groups in California with a mission to "leading and position community clinics, health centers, and networks through advocacy, education and services…" (CPCA 2019).

Another release included commentary from a palliative care physician, Danny Cox, who elaborates on the internal conflict physicians experience when they are approached by patients asking for PAS. In particular, Dr. Cox highlights that the ethical tension produced by these requests are irrelevant in light of the political and cultural changes that have transformed end of life healthcare:

> "Whether or not it is good for the field, no matter what our ethical beliefs, the passage of the law has changed things. There has been this sudden shift that we can no longer ignore. Patients will continue to turn to us because we are experts in end-of-life care, *and this is now an end-of-life option*." (2015)

He later identifies *how* medical professionals can respond to such widespread pressure for PAS:

> "*I believe that if we provide accessible, high-quality palliative care focused on meeting medical, spiritual, and psychosocial needs, physician-assisted death will remain an option of last resort* for our patients here in California."

Right-to-die media releases like those above illustrate how movement frames less frequently objected to medical norms around death and dying. Releases began to articulate PAS as compatible with existing medical standards and incorporated medical professionals' caution toward PAS by insisting on its ability to strengthen mainstream medical practices. Under new right-to-die frames, PAS was 'an option of last resort' that could *at worst* spur healthcare to provide better medical treatment for those at the end of their life. One right-to-die release summarizes this reorientation in framing best:

> "'Medical aid in dying harms no one and benefits even those who make no request for end-of-life medication, by spurring conversations about all their end-of-life options, including hospice and palliative care, and better utilization of them,' said Dr. Omega Silva, a retired physician and former president of the American Medical Women's Association and D.C. resident who has three cancer diagnoses." (2017)

Alongside the increasing emphasis on palliative care, another theme presented—that the real success of PAS was when it remained unused. Media releases under this framework argued that PAS' real value was in its ability to provide 'comfort.' This approach differed from the frames of the late 1990s and early 2000s which focused on how PAS empowered people to take control of when and how they died. Carrying-out PAS was essential to taking back control which right-to-die groups reiterated was held by medical professionals. But as PAS statistics rolled-in from states where it was legal, they began to paint a different picture of the practice:

> "Compassion & Choices of Washington (C&C)…today responded to the Washington State Department of Health's (DOH) report on the state's first full year of experience with the DWDA. A significant number of patients who received medication died without taking it, showing the benefit of comfort and control the law provides…The practice of aid in dying in Washington has been infrequent, and *comforts many more patients than just those who use it. Patients have benefited from the peace of mind and comfort the law provides*" (2011).

And when another report on California's Death with Dignity law illustrated the same trend, one right-to-die organization doubled-down on what the law was actually intended for:

> "Of 258 California residents who started the end-of-life option process under the Act last year, 191 received medication with prescriptions written by 173 doctors. While the Department cautions about drawing conclusions from a partial year report, the data point to what we know from Oregon and Washington: A significant portion of those who obtain prescriptions choose not to use them: 42 percent in California (45% in Oregon). As in Oregon and Washington, the first report out of California shows that the new *assisted dying law works as intended, providing peace of mind, comfort, and control at the end of life* to dying Californians" (2012).

Despite the reality that death with dignity legislation has always been intended to allow people to *act* on PAS without criminal consequences, the shift in right-to-die framing reflected a strategy that did more than simply deflect inconvenient statistics. By insisting that PAS provides existential comfort ahead of control over death and dying, right-to-die organizations reinforced the relative safety in accepting a new medical treatment that both strengthens standard end of life options and is rarely taken advantage of. This softening of PAS ultimately diminished the life and death stakes surrounding its legalization, but it also made its incorporation into general medical practice more palatable for medical professionals. The right-to-die coalition with the California Primary Care association attests to the impact of this framing shift.

A New Good Death

In adjusting frames to focus attention on existing end of life care options and the more abstract comfort PAS could provide terminal patients, right-to-die organizations radically reconstituted what a 'good death' represented. The general pattern of right-to-die framing in the post-coalition period concluded that PAS was just *one option* out of many at the end of life. And consistent with these broader changes, a good death became a more deliberative and even cautiously contemplative healthcare process. Two recent releases illustrate this shift:

> "This [Washington D.C] bill allows someone who is on death's doorstep the option to choose a peaceful death- to decide in one's final moments, when the illness is terminal and death is imminent, how he or she will face the end," said Councilmember Mary Cheh (D-Ward 3), the bill author. *"It is a choice among many one could make…"*" (2016)
>
> "Wolf Breiman, whose cancer prompted him to publicly support legislation to give terminally ill Californians the option of medical aid in dying, died peacefully from pneumonia on December 31. *He passed away at a hospital, while surrounded by his wife, Debbie Diamond, family and friends.* He was 89… Before the End of Life Option took effect, he told to the Ventura County Star: "life is no longer a choice for me. That choice is no longer there. I can choose only how to die." Wolf planned to obtain the medication as soon as he met the law's requirement of having six months or less to live. *Then, he would decide if and when to use it*." (2018)

And in a relatively recent reversal of longstanding movement frames, the last example above notes an emerging context for post-coalition death and dying—hospitals. For comparison, a right-to-die release from 2016 highlights the idealized context of a good death before the presence of hospitals. The release describes the staging of one terminal patient's death, Brittany Maynard. It describes how the course of her disease has made the simple act of breathing painful and deprived her of all energy. Maynard concludes the interview with a solemn resolve that she 'is ready':

> "After completing the request process [for PAS] she invited her closest friends and family for a farewell party. Together, they laughed and cried as they shared memories and stories. A week later, she gathered a handful of people closest to her, laid down on her bed, and drank the liquid medication. She soon fell asleep, and not long after, she died." (2016)

In all, a dramatic transformation occurs between the pre- and post-coalition periods of the right to die movement. This shift in framing progressively medicalized PAS through portrayals of death and dying that increasingly eschewed the prominence of choosing death or exercising a 'right to commit suicide.' Right-to-die groups instead embraced more personally deliberative and medically cooperative approaches to PAS and was resituated in a broader medical approach that *complimented* existing treatment standards. To that end, the framing of a good death today contradicts pre-coalition constructions of death and dying by stressing the centrality of medicine in facilitating end of life treatment. And while it is still a recent development, good deaths have begun to incorporate the presence of hospitals—locations which pre-coalition frames argued prolonged suffering and unnecessary treatment (i.e. bad deaths). In this way, right-to-die frames have increasingly foregrounded mainstream medical standards and infrastructure at the end of life. New right-to-die frames therefore emphasize that PAS is fully compatible with existing medical interests and standards—ultimately facilitating the key medical alliances that emerged from media releases: (1) presentations on clinical practice guidelines for end of life care with the Vermont Ethics Network and (2) the partnership with the extensively connected California Primary Care Association alongside the Doc2Doc service.

Right-to-Life Frames

A Stable Disability Rights Framework

As I described in the introduction, right-to-life organizations represent a unique negative case to compare with right-to-die groups. This is because while right-to-die frames have changed considerably over time, right-to-life frames have remained stable. Their framing of PAS has consistently centered around an understanding that whether a person thinks or feels their life is worth living, is dependent on how society treats them. And if society views people with disability and terminal illness as burdens or valueless, then they would be unfairly pressured to feel the same way. For this reason, right-to-life organizations contend that PAS legislation is just the first step on the slippery-slope of state-sanctioned euthanasia. They argue that despite the protections offered by death with dignity legislation, those with disability, the vulnerable, and those with terminal illness will effectively be denied adequate healthcare access and pressured by society (either overtly or covertly) to choose PAS. And from my coding of right-to-life media releases, that core disability rights argument is the same today as it was in 1996.

Again, in contrast to the right-to-die movement right-to-life organizations have experienced relatively little outside pressure to innovate their frames—they are in fact successfully resisting PAS which is still not legal in 43 U.S. states. And though the right-to-die movement clearly reacted to both the 2006 Supreme Court ruling and to PAS neutrality among key medical organizations, the right-to-life movement has evidenced a reluctance to engage in broader coalition activity. Significantly, they were the only ones to contain media releases which documented their outright rejection of potential partnerships with outside organizations. Still, right-to-life groups did often refer to their broad network of coalitions:

> “In the 12 years since Oregon legalized PAS, not one state has followed suit despite repeated attempts by activists. For this latest [right-to-die] attempt in Vermont, a sizable war chest was used to hire a field director and professional lobbyists, and to conduct an expensive opinion poll. Local media coverage, by and large, was already favorable to

> their cause. *But, in the end, a dedicated, broad-based opposition coalition consisting of -- medical, disability rights, and suicide prevention organizations-- managed to put an end to activists' hopes of bringing PAS to the East Coast, at least for now*." (2006)
>
> "DREDF [Disability Rights Education & Defense Fund] is pleased to announce, along with our *coalition partners in Californians Against Assisted Suicide, that this week, the national organization Patients Rights Action Fund* will launch a new web page where concerned individuals, family members, and friends can bring to light abuses, problems, and complications associated with assisted suicide laws." (2016)
>
> "ADAPT is a grassroots disability rights organization with chapters in 30 states. It uses nonviolent direct action in order to bring attention and awareness to the lack of civil rights the disability community experiences. Not Dead Yet is a national, grassroots disability rights group that opposes legalization of assisted suicide and euthanasia as deadly forms of discrimination against old, ill and disabled people. Not Dead Yet helps organize and articulate opposition to these practices based on secular social justice arguments." (2016)

But regardless of the claims to broad networks of coalitions, right-to-life frames persistently focused on a single disability rights concern and media releases that were sampled did not capture substantive descriptions of coalition activity among organizations outside of right-to-life groups[8]. Instead of coalition activity though, 49 of the 100 media releases I coded described how the real issue in legalizing PAS was that it devalued the physically disabled and vulnerable, and another 59 releases emphasized that PAS under a broken medical system would mean patients could never again trust their healthcare providers.

The first sampled media release for the right-to-life movement described how the core mission of the then new social movement organization, Not Dead Yet (NDY), was a direct response to the growing acceptance of PAS. They argued that this had very fatal consequences

---

[8] On this point, while PAS legislative failures may have been described as successful coalition activity involving 'many grassroots' or broad-based organizations, who ultimately framed the issue for the public convincingly, media releases did not evidence specific coalition events, conferences, etc. among specifically named organizations. The caveat once again is that right-to-life groups often referred to 'broad coalitions' among many types of organizations (medical included), but did not name specific groups or coalition activity outside of anti-euthanasia, ant-PAS, and disability rights groups (right-to-life organizations).

for those with disability:

> "Called NOT DEAD YET!, it was created in response to the growing popularity of physician assisted suicides in this country. Many people fear that this slippery slope could *lead to the systematic extermination* of people with disabilities." (1996: emphasis in original)

This slippery-slope argument and its associated fear for the forced death of those with disability, extends well into the mid-2000s:

> "Two activists in wheelchairs, Duane French of Lacey and Joelle Brouner of Olympia, spoke against the law in a news conference that followed the one featuring Gardner. French and Brouner said the law could create a coercion for some disabled people who are faced with difficulty getting palliative, or non-curative, care. *French said some could be pressured by family or by economic forces into taking their lives.*" (2008)
>
> "*We disabled people, whose lives frequently look like the lives of people requesting suicide*,do not feel that our dignity is compromised because we depend on others for physical care, or because we are not continent every hour of every day [sic]." (2008)

And today, the same message is still articulated:

> "'NDY's primary legal argument against assisted suicide laws is that they discriminate by *giving some people suicide prevention and others suicide assistance* based on illness and disability in violation of the ADA,' said Diane Coleman, president and CEO of Not Dead Yet." (2018)

Bad Deaths

But as a critical point of departure from right-to-die media releases, right-to-life depictions of 'bad deaths' represented nearly half (44) of all media releases. In contrast, one-tenth of right-to-life media releases portrayed some instance of death as 'good.' For comparison, nearly half of all right-to-die media releases (49) described particular instances of death as 'good,' and nearly one-quarter (20) were depicted as 'bad.' The reason for this inversion may be linked to movement-countermovement processes (Meyer & Staggenborg 1996), where right-to-die frames of good death are deconstructed and resituated by right-to-life groups as bad death.

But, right-to-life framing of 'bad' deaths particularly focused on undermining medical patronage by emphasizing the uncertainty of medical evaluations to determine who ‘terminal’ patients are. And bad deaths questioned medical professionals’ ability to avoid prejudice against vulnerable populations—important concerns when PAS laws grant increasing authority and power to medical professionals:

> “When asked how this woman or the other two patients could be considered “terminally ill,” Holden explained, *“The definition of terminally ill, of course, is six months or less, and we knew that all three of these patients would die in six months or less if they stopped eating.” Thus, the patients were judged to be terminally ill.”* (1998)
>
> “In May, Barbara Wagner, 64, found out that her lung cancer had returned after two years of being in remission. Her oncologist prescribed the drug Tarceva because, he told her, it could extend her life by slowing the cancer’s progression. But, her health care insurer, the Oregon Health Plan…refused to pay the drug’s $4,000-a-month price tag. According to the unsigned letter she received from the plan, ‘Treatment of advanced cancer that is meant to prolong life, or change the course of this disease, is not a covered benefit of the Oregon Health Plan.’ *What the letter said it would cover, however, is palliative or comfort care that, includes physician-assisted suicide*” (2008)
>
> “As we’ve seen over the past few decades, narrow initiatives like this act as door-openers, in which a *narrowly-defined ‘refusal’ of life-sustaining treatment expands over time both in terms of the groups who may exercise this ‘right’ and the level of proof a surrogate needs to ‘exercise’ that right on the behalf of someone* who cannot communicate those wishes themselves. What makes this initiative a bold step is *that it shifts manual assistance in eating and drinking as a form of medical assistance --a radical difference in framing something that has historically viewed as basic care*.” (2018)

Right-to-life frames also stressed that family and friends could work against the interests of terminal patients with the help of disinterested physicians. In these case, fatal prescriptions could be filled for medically unnecessary conditions. While right-to-die groups painted the quintessential picture of a PAS death involving friends and family celebrating together just before they peacefully fall asleep, right-to-life groups framed these situations in more abusive terms:

> “It’s been a year since my uncle opted for assisted suicide. To me it’s an excruciating anniversary. He talked about this for a year before it became law. He’d had surgery for cancer which left him with a catheter. He was depressed at 94 but was home with assistance from friends and health givers. I thought this could never happen because he was just old

> and depressed. When the law became reality, friends helped him with his quest. They took him to doctors that my uncle convinced this was what he wanted. His profession had been car salesman so he got the doctors to sign off on him. Friends who were his caretakers tried to talk him out of it, saying it wasn't right because he wasn't terminal. *The date was set for the final event. I loved him and wanted to be with him when he died. It felt like an execution.*" (2010)

In many of the media releases, right-to-life organizations were critical of associating optimism with PAS while a broken medical system specifically discriminates against those with disabilities. One of the very first right-to-life releases is illustrative:

> "Hard to imagine [widespread murder of those with disabilities] in a country that has the strongest civil rights protections for people with disabilities in the world? Well consider what is taking place in our country…
> 2. Increased use of cost-benefit vs quality-of-life analyses of the lives of people with disabilities.
> 3. Frequent interpretation in managed care, as a method to "control" health care costs, of people with disabilities' needs as too expensive.
> 4. Expansion of attempts to eliminate guarantees and minimum standards in the Medicaid program.
> 5. Growth of attacks, based on fears about the cost of our civil rights, against Americans with disabilities." (1996)

Right-to-life frames also often emphasized the destructive combination of a broken medical system with PAS legislation. Releases highlighted the effect on the largest disabled community, the elderly:

> "*There are other ways to promote the premature deaths of old, ill and disabled people* other than assisted suicide, euthanasia, and 'futility' policies. One way is to chop away at their health care. (2008)
>
> "A major concern among disability groups is the risk of abuse of elders and people with disabilities. 'The clearest explanation that I've heard about the problems with abuse in the context of assisted suicide come from elder law attorney, Margaret Dore,' says Coleman. *'Margaret calls assisted suicide laws a 'recipe for elder abuse.'*" (2013)

These frames continue to today, focusing attention on widespread elder abuse and the murder of the disability community, which PAS only ensures under the American healthcare system:

> "'*The legalization of assisted suicide puts me and others with disabilities at risk'*, said Anita Cameron, one of the organizers of the protest, and a member of Not Dead Yet. 'Due to our flawed health care system, it costs much less to kill me than to care for me. I'm at higher risk of abuse and coercion, so my 'right' to die evolves into my duty to die." (2014)

> "Why are they opposed? *This is not about people's option to commit suicide, which is not illegal. This is about how the health care system upon which we all depend responds to a person who says they want society's agreement with their suicide and the means to do it.* We are worried about health care cost-cutting pressures. Assisted suicide by doctors is a deadly mix in a profit-driven health care system.We are also worried about putting lethal drugs in the home of a seriously ill person in a society where one in 10 elders are abused, mostly by family. The claim that there are 'safeguards' doesn't make it so." (2016)

The consistency of these themes was a surprising finding in comparison to the right-to-die media releases. Whether PAS was a fatal recipe, or a symptom of widespread discrimination, the message remains principally the same: PAS legislation is a slippery slope toward the systematic elimination of those with disabilities and the vulnerable, because medical professionals cannot be trusted when healthcare is not evenly distributed. In reframing death and dying, one media release summarizes the principle aim of the right-to-life movement:

> "Personal assistance services are funded by Medicaid and they are the kind of long term care that keeps people out of nursing facilities so they can enjoy basic freedoms like everyone else. But Medicaid still forces too many people into nursing facilities against their will. It's time to start saving money, not by cutting Medicaid, but by reforming it to reverse the institutional bias. I've heard people say they'd rather die than go to a nursing home. It's not a home and no one should be locked up in one because they live in a state that doesn't offer the choice of Medicaid personal assistance in a person's real home. *And no one should have to die because of Medicaid cuts that deny them basic health care. We're going to fight to protect Medicaid. It's a life and death issue and we're Not Dead Yet*!" (2011)

Identity and Framing

Two media releases provide some indications for why right-to-life frames have changed very little over the past two decades. In the first release, right-to-life advocates elaborate on a decision to proactively reject partnering with an organization called the Family Research Council (FRC).

The right-to-life group, Not Dead Yet (NDY), detailed how the FRC sent out invitations to discuss coalition options with two other disability rights groups: the National Council on Independent Living and Second Thoughts. NDY and the Disability Rights Education & Defense Fund (DREDF) were two prominent disability rights groups who were not extended invitations. In responding to their exclusion, NDY wrote:

> "We've had a lot of practice, them and us [already formed disability coalition], leaving our disagreements at the door. *We agree that legalizing assisted suicide is extremely dangerous public policy for old, ill and disabled people, including the general public in ways people often don't recognize.But this invitation from the Family Research Council (FRC) is different. There was no advance contact with the most active disability groups on the issue.* In contrast, new coalitions were already forming in Maryland, Pennsylvania and Colorado, but those groups came together through careful outreach, preparation and mutually agreed ground rules. Face to face meetings, if any, should be held in a neutral setting such as a hotel. None of this happened with FRC, yet our disability rights colleagues who received this invitation would have no way of knowing that." (2015)

The fact that DREDF and NDY had not received coalition invitations appeared to have primarily offended both groups, who saw themselves as the leading disability organizations for opposing PAS. But their offense was just one facet of a much more fundamental concern—it also represented a threat to right-to-life framing strategies. What's more, the right-to-life group also sent out official letters to *all* of the disability rights groups that received FRC invitations. In these letters, they describe why organizations like the FRC interferes with disability rights frames:

> "We have heard from a few folks in the disability community who have received the invitation below from the Family Research Council (FRC). FRC did not engage in any preliminary planning with NDY or DREDF, nor even notify us of this effort. Sending the message from FRC and holding the proposed meeting at FRC's offices *indicates a serious failure to recognize how it undermines the real coalitions that already exist or are forming, and threatens to paint opposition to assisted suicide laws as connected with the other policy positions that FRC is known for*. We hope that disability advocates will not RSVP and will instead put energy into the genuine broad-based coalitions that are working to oppose assisted suicide bills in the states where they are being introduced. We would be glad to help you connect with them." (2015)

This case reveals that right-to-life groups have asserted their political influence to position themselves as the guides to more ‘genuine’ anti-PAS social movement activity. As their reaction to the FRC indicates, maintaining control of right-to-life frames has been a fundamental concern for right-to-life groups. But more critically, by constraining their framing of PAS to a singular disability rights issue, they have blocked opportunities to build coalitions with outside organizations. To emphasize this point, the right-to-life release more explicitly described their concern for engaging in coalitions with outside organizations:

> “Every major national disability group that has taken a position on assisted suicide opposes these laws due to the dangers of mistake, coercion and abuse. *But C&C* [Compassion & Choices] *is out there claiming that their only real opposition comes from the religious right, and promoting opinion pieces from two disabled individuals who agree with them. One reporter even pressed upon one of NDY’s LGBT Board members that she must be a closet conservative. Enough already.*
>
> Disability organizations, like policy makers, have a duty to consider the risks that proposed laws pose to everyone, not just a few... All of these mean that we cannot sit by silently while assisted suicide bills are falsely marketed as a progressive social cause. *We’re willing to work with medical, palliative care, hospice, religious and pro-life organizations in broad coalition to defeat these bills, but coalition presumes equity, good faith and an ability for all members to keep their eyes on the prize. Sadly, we don’t see that in FRC.*” (2015)

And according to the same release, at least one other disability rights organization withdrew their participation in solidarity, noting that FRC “was a bridge too far.”

Two aspects of this right-to-life coalition rejection are critical: (1) that right-to-life organizations evaluate coalition work by its alignment with a disability rights framework and (2) that right-to-life organizations prioritize movement frames that highlight “medical mistakes, medical devaluation of [disability] lives…and abuse” (2015). And in a media release eight months after the rejection of FRC coalition work, one right-to-life group once again separated their movement from the interests of the religious right:

> “*…opponents told the media that we should be dismissed as mere “puppets” of the religious right*. As our voices grew and that strategy worked less and less, we were

> dismissed as having unreasonable fears, unsupported by the facts. *But the reality is that we live on the front lines of a health care system, with long term health issues that give us a better informed perspective on the weaknesses of that system and the ways that it too often fails to meet its stated goals*." (2015)

Ultimately, right-to-life media releases suggested that the stability of their movement frames was heavily influenced by a disability rights identity. Right-to-life organizations consistently focused frames around firsthand experiences with disability, and disability discrimination in the delivery of medical care. These frames represented singular and essential concerns for right-to-die groups in preventing PAS legislation from passing. And in the interest of protecting that core disability rights framework, right-to-life groups have been willing to reject coalition opportunities. Right-to-life media releases underscore the unique and important role that identity can play in how social movement frames change, or don't change, over time.

VI. Discussion/Conclusion

This paper has explored how frames have changed over time for two assisted suicide social movements—the right-to-die and the right-to-life. The findings have been based on the content analysis of 200 randomly sampled media releases that span 23 years (1995-2018) of social movement activity.

Right-to-Die Frames and Coalition Activity

The major right-to-die organizations have profoundly changed their framing of PAS in response to a key external pressure: the 2006 Supreme Court ruling, *Gonzales v. Oregon.* As I have shown, the court decision provided a unique protection for PAS legislation that right-to-die groups took hold of by aligning frames with the interests of medical organizations. They accomplished this in two ways: (1) by resituating PAS to be compatible with existing end of life options, and (2) diminishing the importance of using PAS and relegating it to an option of last-resort. These transformations in framing were supported by the changing right-to-die ascriptions of death. Good deaths *before* the Supreme Court ruling highlighted greater freedom at the end of life: they could determine for themselves when illness or disability were tolerable, maintain their dignity, and resist medical authority. But following *Gonzales v. Oregon,* a good death reflected the changing coalition interests of the right-to-die movement. It therefore depicted positive experiences in death and dying involving partnerships between patients and their doctors, an engagement with all end of life options before considering PAS, and most recently, hospitals.

Coalitions among right-to-die organizations highlight how framing activity in social movements is not always determined by a need to mobilize potential activists. The 2006 Supreme Court decision indicates that in the case of the right-to-die movement, it was a critical external event that encouraged organizations to adjust their framing tactics to limit legal and political contests. The right-to-die movement is therefore a unique case involving two different motivating factors for framing dynamics. Before *Gonzales v. Oregon*, right-to-die frames were mainly concerned with mobilizing activists and accordingly framed PAS as a necessary civil liberty amid bad death and dying, at a time when the public was increasingly unsettled by medical authority (Purvis 2012). Pre-coalition right-to-die framing decisions are generally consistent with existing social movement scholarship on the topic in this way. But after twelve years of legal setbacks and Supreme Court resistance to pre-coalition right-to-die frames, *Gonzales v. Oregon* represented a new opportunity for right-to-die groups to establish more resilient frames. Motivated by this key external event, right-to-die groups modified their depictions of PAS and death and dying to encourage outside partnerships with the 'medical regimes' that the 2006 Supreme Court opinion identified as critical to the legitimacy of PAS as a medical treatment.

Right-to-Life Frames and Coalition Resistance

The right-to-life movement represents a significant negative case in the face of right-to-die frame dynamics. Right-to-life organizations have generally maintained a singular frame for over two decades. As I have illustrated, they contend that PAS accentuates discrimination against the vulnerable and those with disability, especially when it is provided by a broken healthcare system. Right-to-life depictions of bad deaths involving exceptional abuse and coercion to push PAS in medically unnecessary circumstances, along with the overwhelming absence of what might constitute a good death, underscores these organizations' insistence that medical professionals should have no authority over death and dying. Right-to-life media releases also indicated that coalitions with external organizations have been rejected by right-to-life groups, who have been deeply concerned with how external alliances could undermine existing disability rights frames. I have shown that two factors are ultimately responsible for the right-to-life movement's framing path: (1) the absence of external events motivating the reformation of movement frames, and (2) the stability afforded by a core social movement identity.

It is also interesting to consider that right-to-life frames have articulated a position on medical authority consistent with pre-coalition right-to-die frames. And some scholars have argued that right-to-die organizations represent a resistance to medical interpretations of death and dying and promote alternative paradigms to approaching the end of life (Timmermans 2005; Hillyard and Dombrink 2001). But media releases in this study suggest that such an account of the right-to-die movement is no longer true. In light of the increasingly convergent interests of PAS with mainstream medical groups, right-to-die frames now articulate PAS as yet another example of medicalization, as some scholars have noted in other contexts (Karsoho et al 2016). This case therefore has clear implications for research on the social construction of death and dying and resistance to medicalization, topics which are paramount in medical sociology.

Conclusion

As with any research endeavor, limitations are an unavoidable aspect of any methodology that is used. Like most qualitative work, one of the main concerns with using media releases from a discrete set of community organizations is how representative they are. The seven organizations investigated in this paper do not encompass all of the groups involved in opposing or supporting PAS legislation and they do not include all of the political and individual members in the U.S. that participate in the process of constructing right-to-die and right-to-life movement frames. In this way, this study cannot fully represent the PAS social movement as a whole. However, these PAS organizations do represent the largest and most politically active communities and are arguably the most influential sites of contentious movement framing in public media for PAS. For this reason, it is argued that these sources provide reliable and representative data.

The present research has primarily contributed to sociological knowledge of how and why social movement frames change over time. While some scholarship on coalitions and framing has suggested that social movement frames reconstitute as a lowest common denominator (Magan 2008), this research supports an alternative route in some cases. Social movements at times may also widely adopt hegemonic frameworks wholesale (e.g. medical), in the interest of responding to new opportunities for success provided by key external events. In addition, this research also contributes to sociological research on physician assisted suicide from integrated social movement and medical sociology perspectives. And this study is the first, to the author's knowledge, that investigates both the role of coalitions and identity in PAS social movements, and how coalition activity is influenced by changes in social movement frames over time. Future research should attempt to develop more generalizable research on how PAS social movement frames have changed over time, as well as how medical institutions have responded to and shaped their frames. Lastly, continued research on PAS might also focus on understanding this issue through the people who participate in right-to-die and right-to-life organizations, both through interviews and internal documents. That kind of research might hope to uncover how members of PAS organizations have understood movement goals and frames over time, and to what extant external factors and personal identity may have influenced participation in activism and influenced leadership decision-making.

Appendix

Table A

Coalition Event	Date
Merging of Compassion In Dying and End of Life Choices	2005
Partnership with Vermont Ethics Network	2014
Partnership with California Primary Care Association and development of Compassion & Choices Doc2Doc Service	2015

Table B

Major PAS Legislation by U.S. State	Date Approved
Oregon Death With Dignity Act, Measure 16 (Passed) Oregon Death With Dignity Act, Measure 51 (Repeal Bill Failed)	November 8th, 1994 November 4th, 1997
Washington Death With Dignity Act, Initiative 1000	November 4th, 2008
Vermont Act 39 Patient Choice At End of Life	May 20th, 2013
California Assemble Bill No 15. End of Life Option Act	October 5th, 2015
Colorado Proposition 106 End of Life Option Act	November 8th, 2016
Washington D.C. Law 21-182 Death With Dignity Act of 2016	February 18, 2017
Hawaii HB No.2739 Our Care, Our Choice Act	April 5th, 2018

References

Abrams, Garry. 1991. "A Bitter Legacy : Angry accusations abound after the suicide of Hemlock Society co-founder Ann Humphry." *Los Angeles Times,* October 23. Retrieved March 25, 2019 (https://www.latimes.com/archives/la-xpm-1991-10-23-vw-283-story.html).

AMA (American Medical Association). 2016. Retrieved December 13th, 2017 (https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0ahUKEwi-9KXSi4jYAhWF8oMKHeA3DvUQFgguMAE&url=https%3A%2F%2Fwww.ama-assn.org%2Fsites%2Fdefault%2Ffiles%2Fmedia-browser%2Fpublic%2Fhod%2Fa16-resolutions.pdf&usg=AOvVaw1eqIJCn89ocRa4yBO3lCNU).

Benford, Robert D. and David A. Snow. 2000. "Framing Processes and Social Movements: An Overview and Assessment." *Annual Review of Sociology*:611.

Biskupic, Joan. 1997. "Oregon's Assisted-Suicide Law Lives On." *The Washington Post,* October 15. Retrieved March 25, 2019 (https://www.washingtonpost.com/wp-srv/national/longterm/supcourt/stories/sc101597.htm?noredirect=on).

Brown, Jennifer. 2016. "Right-to-die initiative headed for Colorado's November ballot." *The Denver Post*, July 5. Retrieved December 5, 2016 (http://www.denverpost.com/2016/07/05/Right-to-Die-colorado-ballot/).

CBS NY. 2019. "Right To Die Advocate: 'Living Has Been Terrific,' But Now She Wants Control Over When It Ends." *CBS New York*, February 6. Retrieved March 25, 2019 (https://newyork.cbslocal.com/2019/02/06/right-to-die-advocate-living-has-been-terrific-but-now-she-wants-control-over-when-it-ends/).

Charatan, Fred. 2006. "Us Supreme Court Upholds Oregon's Death with Dignity Act." *BMJ : British Medical Journal* 332(7535):195-95.

Charmaz, Kathy. 2000. *Grounded Theory: Objectivist and Constructivist Methods*. Thousand Oaks, CA: Sage.

Cohen, Jonathan S., Stephan D. Fihn, Edward J. Boyko, Albert R. Jonsen, and Robert W. Wood. 1994. "Attitudes toward Assisted Suicide and Euthanasia among Physicians in Washington State." *New England Journal of Medicine* 331(2):89–94.

CPCA (California Primary Care Association). 2019. "About Us." Retrieved March 25, 2019 (https://www.cpca.org/CPCA/CPCA/About/CPCA/About/About_Us.aspx?hkey=8b0299a8-a84c-48ca-ae65-1cfe9381a395).

Craig, A., B. Cronin, W. Eward, J. Metz, L. Murray, G. Rose, E. Suess and M. E. Vergara. 2007. "Attitudes toward Physician-Assisted Suicide among Physicians in Vermont." *Journal of medical ethics* 33(7):400-3.

Dixon, Marc and Andrew W. Martin. 2012. "We Can't Win This on Our Own." *American Sociological Review* 77(6):946–69.

DREDF. 2019. "Timeline." *Disability Rights Education & Defense Fund,* 2019. Retrieved March 25, 2019 (https://dredf.org/about-us/timeline/).

DREDF. 2005. "Million Dollar Baby Built on Prejudice about People with Disabilities." *Disability Rights Education & Defense Fund,* February 2005. Retrieved March 25, 2019 (https://dredf.org/2005/02/13/million-dollar-baby-built-on-prejudice-about-people-with-disabilities/).

Final Exit Network. 2019. "FREQUENTLY ASKED QUESTIONS." *ERGO,* Jan 2, 2019. Retrieved March 25, 2019 (http://www.finalexit.org/ergo_faq.html#15).

Glaser, Barney G. and Anselm L. Strauss. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine Publishing.

Gonzales v. Oregon, 546 U.S. 243 (2006).

Hilgartner, Stephen. 2000. *Science on Stage Expert Advice as Public Drama*. Stanford, CA: Stanford University Press.

Hillyard, Daniel and John Dombrink. 2001. *Dying Right*. New York, NY: Routledge.

Karsoho, Hadi, Jennifer R. Fishman, David Kenneth Wright and Mary Ellen Macdonald. 2016. "Suffering and medicalization at the end of life: The case of physician assisted dying." *Social Science & Medicine*, 170: 188-196.

Lee, Melinda A., Heidi Nelson, Virginia Tilden, Linda Ganzini, Terri A. Schmidt and Susan W. Tolle. 1996. "Legalizing Assisted Suicide — Views of Physicians in Oregon." *New England Journal of Medicine* 334(5):310–15.

Magnan, André. 2008. "Strange Bedfellows: Contentious Coalitions and the Politics of GM Wheat*." *Canadian Review of Sociology/Revue Canadienne De Sociologie* 44(3):289–317.

Majchrowicz, Michael. 2016. "The Atlantic." *The Atlantic*, July 6. Retrieved December 5, 2016 (http://www.theatlantic.com/health/archive/2016/07/the-volunteers-who-help-people-end-their-own-lives/489602/).

Meyer, David S. and Suzanne Staggenborg. 1996. "Movements, Countermovements, and the Structure of Political Opportunity." *American Journal of Sociology* 101(6): 1628-1660.

MMS (Massachusetts Medical Society). 2017. Retrieved December 13th, 2017 (http://www.massmed.org/News-and-Publications/MMS-News-Releases/Massachusetts-Medical-Society-adopts-several-organizational-policies-at-Interim-Meeting/#.WjGg0jdG3D4).

Plato. C. 427-347 B.C. *Plato's Apology, Crito and Phaedo of Socrates*. eBook: CreateSpace Independent Publishing Platform. Translated by Henry Cary.

Purvis, Taylor E. 2012. "Debating Death: Religion, Politics, and the Oregon Death With Dignity Act." *Yale Journal of Biology and Medicine* 85(2): 271-284.

Reinhold, Robert. 1990. "Right-to-Die Group Is Shaken as Leader Leaves His Cancer-Stricken Wife." *The New York Times*, February 8. Retrieved March 25, 2019 (https://www.nytimes.com/1990/02/08/us/right-to-die-group-is-shaken-as-leader-leaves-his-cancer-stricken-wife.html?auth=login-email).

Scoccia, Danny. 2010. "Physician-Assisted Suicide, Disability, and Paternalism." *Social Theory and Practice,* 36(3): 479-98.

Shapiro, Joseph P. 1994. *No Pity: People with Disabilities Forging a New Civil Rights Movement.* New York, NY: Times Books.

Small, Mario Luis. 2009. "'How many cases do I need?' On science and the logic of case selection in field-based research." *Ethnography* 10(1): 5-38.

Snow, David and Robert Benford. 1988. "Ideology, Frame Resonance, and Participant Mobilization." *International Social Movement Research* 1:197-217.

Snow, David A., E. Burke Rochford, Jr., Steven K. Worden and Robert D. Benford. 1986. "Frame Alignment Processes, Micromobilization, and Movement Participation." *American Sociological Review,* 51(4): 464-81.

Timmermans, Stefan.2005. "Death brokering: constructing culturally appropriate deaths." *Sociology of Health and Illness,* 27(7): 993-1013.

Timmermans, Stefan and Iddo Tavory. 2012. "Theory Construction in Qualitative Research: From Grounded Theory to Abductive Analysis." *Sociological Theory* 30(3): 167-186.

Vacco v. Quill, 521 U.S. 793 (1997).

Washing v. Glucksberg, 521 U.S. 702 (1997).

Weil, Martin. 2013. “Sixty Protesters with the Disability Organization ADAPT Arrested at White House.” *The Washington Post*, October 1. Retrieved December 5, 2016 (https://www.washingtonpost.com/local/sixty-protesters-with-the-disability-organization-adapt-arrested-at-white-house/2013/09/30/68ff3576-2a37-11e3-8ade-a1f23cda135e_story.html?utm_term=.b7b7f1313a32).