

Framing Dignity in the Debate on Requested Death

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Abstract: Requested death raises ethical questions about autonomy, dignity, and protecting vulnerable populations. This paper defines 'requested death' as patient-initiated end-of-life practices, including PAS (where the physician provides but does not administer the means), euthanasia (where the provider performs the act), and death with dignity laws (which permit self-administered aid under certain conditions). This study uses Charmaz's grounded theory and Rhoades and Rhoads' discourse analysis to examine how both sides use narrative framing and advocacy to shape policy and public opinion. Supporters emphasize autonomy and compassion. Critics stress risks to marginalized groups and appeal to shared responsibility. The analysis uses media, legal, organizational, and personal sources to examine how the meanings of dignity are constructed and contested. The findings advocate policies that address individual and structural factors in end-of-life care.

Keywords: autonomy, dignity, euthanasia, physician-assisted suicide, vulnerability, social movements

Introduction

The debate over requested death raises ethical, legal, and social questions. Patients, clinicians, advocates, and policymakers face challenges balancing personal autonomy with collective ethical obligations. Proponents argue for independence and compassion for people making end-of-life decisions (Compassion & Choices, n.d.; Maynard, 2014), while opponents emphasize risks to vulnerable populations, particularly the elderly and disabled (Gill, 2004; Not Dead Yet, 2021). At the center of this debate is the concept of dignity, which both sides frame to align with cultural values, shape policy, and sway public opinion.

Theoretical Framework and Methods

This study analyzes the contested concepts of autonomy, dignity, and vulnerability in the debate over requested death. Drawing on Charmaz's constructivist grounded theory (2014), the research explores how these concepts are constructed and redefined within public discourse. Proponents define autonomy as self-governance and emphasize its centrality to end-of-life decision-making. Critics stress dignity as a collective duty to protect vulnerable people. In turn, vulnerability highlights systemic inequities that restrict the autonomy of marginalized groups. Rhoades and Rhoads (2003) on social movement discourse and Benford and Snow (2000) on collective action framing complement these insights. Together, they illuminate the use of advocacy narratives to shape public opinion and mobilize support.

This study uses four primary sources: organizational statements, personal narratives, media reports, and legal filings. Groups like Compassion & Choices stress autonomy and dignity, while Not Dead Yet frames PAS as reinforcing ableism and systemic bias (Coleman, 2022; Not Dead Yet, 2021). Brittany Maynard's widely known story of accessing Oregon's Death with Dignity Act illustrates the ethics of autonomy and suffering (Maynard, 2014). Counter-narratives from disability rights activists draw attention to societal pressures that limit marginalized individuals' choices (Behuniak, 2011; Gill, 2004). Media reports and legal filings further contextualize these debates, providing broader legal and cultural perspectives.

The data analysis utilized Charmaz's (2014) two-stage coding method. This approach involves initial and focused coding to identify recurring themes. Reflexivity encouraged critical awareness of the investigator's assumptions and cultural perspective throughout the study. This approach ensured a balanced and sensitive interpretation of participant views while maintaining methodological rigor. This study demonstrates how advocacy groups frame autonomy, dignity, and vulnerability in shaping public discourse on requested death.

Vulnerability encompasses health conditions and structural disadvantages such as poverty, discrimination, and lack of access that constrain autonomy.

Perspectives on Requested Death: Autonomy, Rights, and Vulnerability

Advocacy groups like Death with Dignity and Compassion & Choices stress the importance of autonomy and dignity in end-of-life decisions. Many of their arguments reflect a broader ethos within the right-to-die movement that emphasizes personal agency and relief from suffering. A 2021 *New York Times* overview by Tara Parker-Pope outlines how aid-in-dying laws operate in the U.S. and reflects the public framing of these policies as matters of personal agency and control over end-of-life decisions (Brody, 2021). Dr. Jack Kevorkian, a controversial yet influential figure in that movement, encapsulated this stance by asserting, “The patient’s autonomy always, always should be respected, even if it is absolutely contrary—the decision is contrary to best medical advice and what the physician wants” (Frontline, 2015).

This view prioritizes individual will over medical judgment, challenging traditional medical ethics. Advocacy organizations similarly root their positions in values of individualism and secular morality, framing PAS and related practices, such as death with dignity laws, as compassionate responses to terminal suffering (Compassion & Choices, n.d.; Haring, 2024). Cases like Brittany Maynard’s illustrate how autonomy and suffering intersect, reinforcing the movement’s moral appeal (Maynard, 2014).

In contrast, opponents caution against legalizing assisted dying, citing risks to vulnerable populations, including the elderly and disabled (Behuniak, 2011). Disability rights groups, such as Not Dead Yet, insist that such policies perpetuate systemic ableism (Behuniak, 2011; Coleman, 2022). They further criticize these policies for fostering societal pressures that may disproportionately affect marginalized groups (Behuniak, 2011; Gill, 2004; Not Dead Yet, 2021). Disability rights advocates emphasize that these pressures are not merely theoretical. As Hale (2018) writes, disabled individuals often feel like a burden, which intensifies the risk of subtle coercion in assisted dying decisions. Venugopal, Flores-Mir, and Vaid (2022) challenge the notion of autonomous choice by pointing to the subtle influence of healthcare providers, advertising, and other factors. Religious organizations opposing PAS emphasize the sanctity of life, framing death as inviolable and sacred (The Catholic Church, Bishops' Conference of England and Wales, 2024; BBC, 2014; Pew Research Center, 2013). To counter PAS initiatives, opponents advocate for enhanced palliative care and a greater societal responsibility to protect vulnerable individuals from coercion or neglect.

Narrative Construction: Stories and Counter-Stories in Public Discourse

Proponents and opponents of assisted dying construct narratives to sway public opinion and influence policy. Proponents share personal stories that emphasize compassion, autonomy, and self-determination (Rushe, 2011). Similarly, Andre and Velasquez (2015) outline these moral perspectives, presenting assisted suicide as a debate framed by deeply held values about personal freedom and ethical responsibility. Brittany Maynard’s widely publicized decision to end her life under Oregon’s Death with Dignity Act illustrates the use of assisted dying to alleviate terminal suffering while honoring individual agency. Her statement, “I want to die on my own terms,” became a rallying cry for autonomy and personal control in end-of-life decisions (Maynard, 2014). These narratives connect requested death to broader rights-based movements, framing it as both an extension of individual freedoms and a solution to unnecessary suffering.

Opponents of assisted dying regularly highlight the ethical risks it poses to disabled and marginalized groups. Disability rights activists and religious organizations, though driven by different motivations, have a history of joining forces against physician-assisted suicide (PAS) legislation. Disability advocates focus on systemic ableism, while religious groups emphasize the sanctity of life. Their alliance serves as proof that concerns about vulnerability cut across ideological lines.

One example from the United States Conference of Catholic Bishops (2017), is the story of John, a man born without arms. John's life defies conventional definitions of independence. He learned to dress himself at 10, drive at 16, and became a father at 37. He advocates for interdependence over self-sufficiency, finding strength and joy in collaborative daily routines, like preparing meals with his wife and daughter. His story is used to challenge the idea that independence defines dignity, encouraging interdependence instead. Such narratives are designed to alter public opinion and reframe popular understandings of autonomy and care within the assisted dying debate.

Kamisar (2012) challenges the emotional, personalized framing commonly used by proponents of PAS. He argues that terms like "death with dignity" and "aid-in-dying" obscure the legal and ethical distinction between allowing death and causing it. The BBC also outlines how such terms can obscure the gravity of intentionally ending life, citing ethical and slippery slope concerns (BBC, 2014). Kamisar notes that while these stories can be powerful, they risk shifting the focus away from broader policy consequences. He emphasizes that although individual cases may appear ethically compelling, legalizing PAS introduces risks that are difficult to contain. The New York State Task Force, which he references, unanimously concluded that even if PAS seems acceptable in isolated situations, its systemic effects would be harmful and disproportionate, particularly for vulnerable individuals (Coleman, 1997).

Both sides complement their storytelling with broader strategies, including media campaigns, legislative lobbying, legal challenges, and grassroots mobilization. By crafting narratives that resonate with societal values, proponents and opponents aim to influence the discourse on assisted dying. Personal stories, whether emphasizing autonomy or interdependence, function to connect ethical principles to lived experiences, deepening public understanding of this complex issue. These contrasting stories reflect opposing ethical frameworks and highlight how cultural values shape the public's understanding of what constitutes a dignified death. Beyond storytelling, however, these movements rely on coordinated strategies to translate ethical appeals into policy, legal reform, and public engagement.

Strategic Approaches of Social Movements in the Requested Death Debate

While stories create emotional and ethical resonance, advocacy movements rely on broader strategic tools to translate those narratives into policy and legal change. In debates surrounding physician-assisted suicide (PAS) and euthanasia, both proponents and opponents employ a range of strategic approaches to shape public opinion, influence policymakers, and advance their causes. These include legislative, media, legal, and grassroots efforts to shape policy.

Legislative advocacy has been central to efforts to legalize PAS. Groups like Compassion & Choices and Death with Dignity frame it as a human right grounded in autonomy, emphasizing bodily self-determination and relief from suffering (Death with Dignity, 2025; Haring, 2024). A lot of their work involves drafting legislation and using personal testimony to humanize the issue. Brittany Maynard's story drew national attention to PAS and brought renewed focus to how it is framed in public discourse. A 2018 Gallup poll found that while 72% of Americans supported "ending a patient's life by painless means," support dropped to 65% when the term "physician-assisted suicide" was used (Brenan, 2018).

On the other side of the debate, critics of PAS include disability rights advocates such as *Not Dead Yet* and religious organizations like the U.S. Conference of Catholic Bishops. They warn that legalizing PAS poses serious ethical and societal risks. One of their main concerns is that eligibility criteria may gradually expand to include individuals with non-terminal conditions. Examples from the Netherlands and Belgium are frequently cited to support this point (Cheng, 2024; Paton, 2024). In the Netherlands, where euthanasia is legal under specific conditions, it has been performed on patients with dementia and others who could not provide explicit consent. In one case, a physician sedated a dementia patient and administered euthanasia while her family restrained her. This occurred despite her earlier

objections and was permitted under Dutch law (Boffey, 2019; Not Dead Yet, 2025; The New York Times, 2019; France-Presse, 2020). In Belgium, a 2010 study found that about half of the nurses involved in euthanasia procedures reported participating in cases without a direct request from the patient. This raises concerns about how consistently consent safeguards are followed (United States Conference of Catholic Bishops, n.d.-a; Inghelbrecht et al., 2010).

The experience of a 22-year-old Dutch woman, who was approved for euthanasia due to severe mental health struggles but chose not to go ahead, illustrates these concerns. Her case raises questions about how well safeguards protect vulnerable individuals (Waterfield, 2024). Critics contend that such cases expose not only individual vulnerability but also societal pressures that emphasize cost-saving measures over comprehensive care (Middlehurst, 2024). The New York State Task Force on Life and the Law likewise concluded that, even if PAS might seem ethically acceptable in individual cases, no legal framework can reliably prevent coercion or systemic abuse (Coleman, 1997). Their unanimous conclusion emphasized the risks to patients who might feel pressured or lack access to alternatives, particularly within an unequal healthcare system. These systemic risks disproportionately affect marginalized groups, such as the elderly, disabled, and mentally ill, who may feel coerced into viewing death as their only option (Middlehurst, 2024; United States Conference of Catholic Bishops, n.d.-a). In addition to expressing concerns about coercion and neglect, professional medical organizations have issued strong ethical objections to PAS. The American College of Physicians (ACP) opposes legalization, stating that the practice undermines the patient–physician relationship and weakens their ethical obligations of beneficence and nonmaleficence (Clinical Advisor, 2017; Sulmasy & Mueller, 2017). According to the ACP, physician-assisted suicide is not a form of treatment and does not resolve the challenges at the end of life. It shifts physicians from healers to agents of death. The ACP asserts that the profession should focus on alleviating suffering through palliative care and strengthening trust between doctors and patients.

Media campaigns play a critical role in shaping public perception and presenting each side's arguments. Proponents rely heavily on emotional storytelling to illustrate the suffering of terminal patients and the ethical importance of choice. Public figures and personal stories, like Maynard's, have been particularly influential in generating sympathy and support. They use digital platforms to expand outreach and connect assisted dying to causes like reproductive and LGBTQ+ rights. Opponents, meanwhile, use media to highlight structural risks of PAS, particularly to marginalized groups. Disability rights organizations use narratives that emphasize systemic ableism and societal bias against individuals with disabilities. Stories from activists illustrate fears that legalizing assisted dying may reinforce stereotypes about the value and quality of disabled lives. Religious groups stress moral imperatives and warn that normalizing death degrades societal values.

Legal challenges are another battleground in the PAS debate. Proponents of assisted dying often pursue litigation to overturn prohibitive laws, arguing that bans on PAS violate constitutional rights, such as the right to privacy, personal autonomy, and dignity. For instance, after Oregon passed its Death with Dignity Act, proponents successfully defended the law in court against challenges that claimed it conflicted with federal statutes. These victories have set important legal precedents and serve as models for other states and districts seeking similar legislation.

Opponents also actively utilize the legal system to challenge PAS laws, framing their arguments around the protection of vulnerable populations' rights. Disability rights organizations, such as the Disability Rights Education and Defense Fund (DREDF), have filed amicus briefs in pivotal cases, highlighting concerns about coercion and systemic inequality. They argue that PAS laws may harm disabled individuals due to biases regarding what constitutes a “life worth living” (United States Conference of Catholic Bishops, n.d.-b). Legal battles reinforce each side's ethics and goals.

Grassroots organization complements these broader advocacy efforts by engaging communities at a local level. Proponents build diverse coalitions that include healthcare professionals, patients, and civil rights organizations. They host events and circulate petitions to educate the public and frame PAS as a compassionate option for the terminally ill (Harris, Richard, & Khanna, 2006). By fostering direct connections with the public, proponents aim to demystify assisted dying and emphasize its alignment with modern values of individual autonomy and dignity.

Opponents mobilize grassroots resistance through organized protests, community forums, and vigils that emphasize the ethical dangers of PAS and the need to protect vulnerable groups. Disability rights activists regularly focus on the intersection of ethics, healthcare, and social justice, arguing that assisted dying laws reinforce systemic neglect of individuals with disabilities. Religious communities organize outreach and distribute materials reinforcing life's moral inviolability. Disability rights groups, notably Not Dead Yet, supplement grassroots efforts with practical tools like their *Disability Rights Toolkit*, which provides advocacy materials, talking points, and legal analysis. This strategic document allows local organizers to link personal testimonies with systemic critiques, reinforcing opposition to PAS as a matter of both ethical principle and civil rights (Not Dead Yet, 2025).

Strategic framing is central to how social movements influence public understanding and rally support. In the debate over PAS, supporters and critics use diagnostic framing to define the problem, prognostic framing to propose solutions, and motivational framing to spur action. These are tools for shaping opinions and policy.

However, both proponents and opponents of PAS face critiques of their arguments. Proponents' emphasis on autonomy risks overlooking the societal and economic pressures that may erode genuine choice for marginalized populations. Conversely, opponents' framing of the sanctity of life can unintentionally disregard the autonomy of terminally ill patients seeking relief from suffering. Addressing these weaknesses requires a nuanced understanding of autonomy as both an empowering principle and a potential site of coercion, particularly in contexts where systemic inequities persist. Future policy decisions must grapple with both the ethical claims of individual autonomy and the responsibilities of medical institutions. These competing frames are not just rhetorical strategies. They reflect deeper tensions within medicine, law, and ethics about how society should respond to suffering at the end of life.

Emanuel and Joffe (2003) argue that legalizing assisted suicide risks eroding the physician's duty to heal and may undermine patient trust, particularly among vulnerable populations. They point to evidence from the Netherlands showing that safeguards have not prevented the expansion of euthanasia practices beyond their original limits. Instead of endorsing assisted death, they call for stronger palliative care and a reaffirmation of medicine's ethical commitment to relieving suffering without causing death.

The American College of Physicians warns that endorsing control over the timing and manner of death as a medical goal would compromise the trust patients place in their doctors (Sulmasy & Mueller, 2017). They argue that physician-assisted suicide conflicts with core medical ethics and threatens to turn end-of-life care into a matter of expediency rather than compassion. Kamisar (2012) reinforces this point by arguing that blurring the legal line between allowing a person to die and actively ending life may create more hidden victims than it resolves, especially when systemic protections are weak. A sustainable and ethical response must prioritize dignity through care, not through the intentional ending of life. These ethical debates do not exist in isolation. They directly influence how both sides construct their public narratives and frame physician-assisted suicide (PAS) within larger cultural and political movements.

Supporters of PAS build their messaging around values like autonomy and compassion to shift public opinion and drive legal change. They present terminal illness and loss of control as urgent personal crises and assert that PAS provides ethical relief while honoring

personal agency. They link PAS to broader rights movements, including reproductive and LGBTQ+ rights, framing it as a compassionate and empowering option within the larger fight for dignity and freedom (Compassion & Choices, n.d.; Harper, 2014; McInerney, 2000). Dr. Jack Keivorkian called assisted dying “the ultimate self-determination,” arguing, “If you don’t have liberty and self-determination, you’ve got nothing... this is what this country is built on” (CBS, 2011). His rhetoric positions PAS not only as a medical or ethical issue but also as a fulfillment of core American ideals about freedom, reinforcing its legitimacy in public discourse. Advocates stress autonomy and compassion to frame PAS as a humane, rational option. They aim to establish PAS as a legitimate expression of personal freedom and a standard component of end-of-life care.

Opponents use similar rhetorical strategies to voice their concerns. They frame PAS as ethically dangerous, especially for vulnerable groups who may feel pressured into it due to poor healthcare, financial stress, or social discrimination (Coleman, 2022; Gill, 2004). They argue that these systemic inequalities can turn PAS into a threat rather than a choice. As an alternative, they promote better palliative care, stronger healthcare infrastructure, and more robust social support. They argue these measures preserve dignity without ending life. Their appeal is rooted in shared moral values and a call to collective responsibility, urging society to protect life and resist normalizing assisted death.

Each side’s framing strategies reveal deep moral, ethical, and cultural divisions in the debate over requested death. These strategies continue to shape public understanding and engagement. Both sides draw on shared values, reflecting deeper tensions in how society addresses end-of-life decision-making.

Conclusions

The debate over requested death reflects tensions over autonomy, dignity, and vulnerability. Supporters emphasize the right to choose how and when to die. They connect these views to cultural shifts toward individual rights and self-determination, presenting assisted dying as a response to suffering and a means of respecting personal agency.

Opponents point to risks for vulnerable groups, including older adults, people with disabilities, and those facing economic challenges. They argue that inequalities and social pressures can limit autonomy, creating situations where people may feel pushed toward choosing death. They call for better palliative care, healthcare access, and community support to affirm life and protect the vulnerable.

This study shows that dignity is not a static attribute, but a socially constructed concept shaped by cultural values and institutional contexts. Autonomy and vulnerability are relational, not isolated. An ethical policy must consider how structures shape choices and responsibilities.

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