

'MEDIA REPRESENTATIONS OF
EUTHANASIA'

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Abstract

For some time now there has been a divergence between public support for euthanasia and its illegal status within British law as well as its rejection by the medical profession. There have been a number of studies of public opinion, and there already exists a wealth of expert literature on the topic, by lawyers, health professionals and philosophers. This thesis argues that the newspaper coverage of euthanasia can be seen as a site where these expert discourses and lay discourses meet. The supporting data consists of a complete enumeration of articles containing the word 'euthanasia' which appeared in British newspapers over a 12-month period from November 1998 to October 1999. These documents were analysed using various forms of narrative analysis and discourse analysis. It was found that whilst both expert discussions and newspaper articles use similar concepts and categories to represent the meaning and practice of euthanasia, there are subtle but significant differences between these discussions. Newspapers also apply these categories in more grounded but less qualified ways. In particular, the 'voluntary euthanasia discourse', which is fundamental for experts, is less important in newspaper articles, where it is secondary to what I call a 'terminal illness discourse'. In that discourse, terminal illness becomes the marker that justifies euthanasia, over and above the concerns of experts. Both the 'voluntary euthanasia discourse' and the 'terminal illness discourse' address issues of agency and responsibility, but they approach these concerns from different assumptions. A striking feature of newspaper articles is that their discussion of euthanasia in terms of moral universals is grounded in the rhetoric of a world divided into nations.

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Chapter (1) – Introduction

Introduction

This introductory chapter has several aims: first of all, it will introduce the substantial topic of this thesis, euthanasia, locating it in an historical and social context as well as sociological thinking. Secondly, the main aim of the thesis will be presented. Following on from this, there will be a discussion of the selection of data for this study. To situate the study in context, the several academic perspectives that this study draws on will be outlined. This section will conclude by indicating my personal interest in this topic and there will be more said about where I, the researcher, am coming from, with a brief natural history of the study that led to the thesis as it stands now. The chapter will end with an overview of the content of the chapters of the thesis.

Euthanasia in context

1. The historical background

According to Kemp (2002), the modern British euthanasia debate can be traced to the early 1870s. From this period there exists documentation of an essentially philosophical debate (drawing on the theological concern with the sanctity of life), not yet including doctors or the general public. Medical practitioners did not enter the debate until the early 20th century, when involuntary euthanasia or ‘mercy-killing’ was on the agenda, without resulting in any practical implementation (‘mercy-killing’ has only ever been a theoretical point for discussion, never resulting in overt social policy - in this country at least, but see Burleigh (1994) on ‘euthanasia’ in Germany). In 1935, the Voluntary Euthanasia Legalisation Society (today Voluntary Euthanasia Society, or VES) was founded in Leicester, with the aim of showing the strength of public support for euthanasia. As Kemp shows, however, ‘the Society’s chosen tactic was to secure legislative reform by establishing a network of distinguished sympathisers able to

influence policy at high levels, rather than by means of populist pressure from below (Kemp 2002, p83). The Society put forward a Voluntary Euthanasia (Legislation) Bill in 1936 which was the first of a series of attempts to change legislation, all of which have so far been defeated. In the post-war period until the 1960s, public attitudes to euthanasia were coloured by the Nazi practice of non- and in-voluntary killing of those they called 'mentally defective', and throughout the 1950s public interest in the cause of the VES was negligible. (During this period, the VES itself was not always clear on what their objectives were in terms of voluntary, involuntary and non-voluntary euthanasia, giving rise to anxieties about a slippery slope of potentially legalised voluntary euthanasia leading to involuntary euthanasia.) By the 1960s, however, medical technology had advanced so much with life-prolonging techniques that the ethical issues around the question of euthanasia became issues of 'enormous practical bearing' (Kemp 2002, p.174), both for doctors and patients. One response to these advances was the development of the hospice movement, and eventually the medical speciality of palliative care. The first hospice (St Christopher's) was inspired by the ideals of its founder, Cicily Saunders, based in the Christian tradition of helping the sick and comforting the dying. While initially palliative care was associated with the ideals of the Western Christian tradition, increasingly now palliative care is being conceptualised in terms of universal, bioethical norms (Ten Have and Clark 2002, p.6). While palliative care deals mainly with the management of pain, including psychological and spiritual anxieties (see Saunders' (1979) concept of 'total pain'), and rejects euthanasia as an option, the euthanasia debate has changed tack since the 1960s 'from a relatively straightforward concern with the relief of pain to challenge the apparent conflict between patient autonomy and the actions of an overly officious medical profession' (Kemp 2002, p.211). A 1994 study (Seale and Addington-Hall 1994) into the reasons for requests of euthanasia found that the problem of feelings of dependency and lack of personal autonomy was rated over and above pain (at least for people without cancer; for people with cancer, pain was significant, too), suggesting that independence and autonomy have become values over which the euthanasia movement and the public converge.

The brief historical and chronological account given above might give the impression that understanding the contemporary euthanasia debate is relatively straightforward. In

fact, commentators differ on the answers to the question of why euthanasia has become such a pertinent issue for us today. One reason is that in the contemporary debate, the issues that emerged in a former historical context have become resources that participants in the debate today draw on when formulating their arguments. Hence, we can see arguments invoking the sanctity of life, the slippery slope, pain and autonomy side by side in the contemporary debate, provoking disagreements over their relative importance for understanding and resolving the as yet unresolved issue of euthanasia.

2. The social context

Much attention has been paid to the social context in trying to explain why euthanasia has become a contentious issue. Emanuel, for example, concludes after a comparison of public discourse on euthanasia in the late 19th/early 20th century in the USA and Britain with contemporary discourse, that:

‘Public interest in euthanasia 1) is not linked with advances in biomedical technology; 2) it flourishes in times of economic recession, in which individualism and social Darwinism are invoked to justify public policy; 3) it arises when physician authority over medical decision making is challenged; and 4) it occurs when terminating life-sustaining medical interventions become standard medical practice and interest develops in extending such practices to include euthanasia’ (Emanuel 1994, p.121).

Emanuel’s conclusions suggest that the status of euthanasia as a contentious and contemporary issue cannot simply be explained by a historical narrative of medical advances and changing social attitudes. It has to be situated in the contemporary social context.

In the social context in which the euthanasia debate is taking place today, it appears that pro-euthanasia advocacy is associated with ‘modern, urban cultural conditions’ (Seale and Addington-Hall 1994). In particular, the conditions leading to pro-euthanasia advocacy draw upon the values of democratic liberalism and a secular consciousness: the

idea that individuals should be able to make decisions regarding their own lives is held to apply equally to the circumstances and timing of their deaths, thus creating a space for the acceptability of euthanasia as an option. Opposition comes mainly from the organised churches, particularly the Catholic Church: the Christian doctrine of the sanctity of human life implies that all life is given by God and should only be taken away by God. According to this conception, human beings have no right to take away life, regardless of the circumstances, which rules out euthanasia in any shape or form. It is possible to see differences between countries in Europe and North America, and also within those countries over time, as the strength of the respective groups representing either the ideals of liberalism or the values promoted by the church are shifting. The liberal Netherlands, for example, has seen a long-standing debate about euthanasia, culminating in the legal regulation of the practice. Only recently, however, with the rise of the right-wing party of the late Pim Fortuyn, calls to reverse euthanasia legalisation are being heard again more widely.

A liberal, secular outlook does not necessarily lead to pro-euthanasia advocacy, however its arguments against euthanasia are different from the principled opposition of the churches: it is rooted in an evaluation of prevailing social conditions. Britain is a deeply stratified society which, in an untypical moment of its history, established a National Health Service, free to all at the point of delivery, which still exists. However, over the last decades, the NHS has been financially starved by consecutive governments and inequalities in health care have been creeping back in (Hutton 2000), with an increasing proportion of people who can afford to pay going private. Waiting lists are long, and, in contrast to countries such as Germany and the Netherlands, where it is usual to have a family doctor who knows her patients intimately over a long period of time, in Britain, the patient only has the right to see 'a' doctor, not his doctor. The apparent inequalities of the system lead to concerns that a law regulating euthanasia could not be adequately controlled. These concerns are less acute in countries where a greater social and economic equality exists (like the Netherlands), yet most acute in the United States, where many people have no right to free health care at all, and the language of 'rights' is the one in which the American euthanasia or 'physician-assisted suicide' debate is conducted (Angell, 1997).

Secondly, there has been a substantial shift in the age structure of British society (as in other developed countries) over the last century with many more old people living longer. Death today more often comes as the result of a long illness at the end of a long life rather than being a sudden event threatening all ages. Advances in medical technology mean that many life-threatening illnesses have been transformed into chronic and manageable ones (like cancer, heart-disease, and – to a certain extent – AIDS) and people can be kept alive even with the severest disabilities. Senility in old age and Alzheimer's disease is an increasing phenomenon. It is against this background that the concept of 'mere life' as a good in itself is being questioned and issues about the 'quality of life' come to the fore.

It is often argued that technological developments in medicine which keep very ill people alive over a long period of time, as even severe illnesses become chronic rather than fatal, have led to a growing interest in euthanasia (see Howarth and Jeffreys, 1996). It may be that more people today will find themselves in situations where they are faced with issues of quality of life, and that might include considerations of euthanasia, although that does not necessarily follow.

Other developments within medicine, for example the shift in the doctor-patient relationship (Armstrong 1984; Gothill and Armstrong 1999), may have contributed to a wider public acceptance of euthanasia. Paternalistic doctors are not uncommon, but their right to making unilateral decisions has been severely questioned and the right of the patient to refuse treatment, even if that decision will lead to death, has been enshrined in British law (Giesen 1998, p.201). Even though there is no comparable right to ask for particular treatments, in the public consciousness the idea that 'doctor knows best' is rapidly disappearing and the British medical establishment's objections to euthanasia are not simply accepted, as opinion polls with a great majority of the British public voting in favour of euthanasia in particular circumstances show.

3. A sociological approach: Durkheim and the euthanasia debate

The positive attitude to euthanasia in large parts of the population raises questions about the nature of moral changes in society. Britain is commonly described as a plural

society, which also implies moral plurality. This extends to beliefs regarding euthanasia. First, there are the pro-life groups that are implacably opposed to euthanasia because they hold that life is sacred and must never be taken, a position usually justified by religious beliefs. Then there are medical practitioners who see their role in curing illness and saving lives, never in taking lives. There are philosophers and ethicists who worry about the 'slippery slope', which expresses the fear that condoning euthanasia, even in very restricted circumstances, would encourage widespread killings and a general disregard for human life. Many in the legal profession see their role in upholding the status quo prohibiting all killing, including euthanasia. On the other side, there are those medical professionals who feel that there are cases of protracted suffering in which euthanasia would come as a blessing. There are legal and ethical philosophers who argue that the law is inconsistent while suicide is legal yet assisted suicide illegal. Friends and supporters of individuals, and those stricken individuals themselves, form the largest part of the pro-euthanasia lobby, claiming that a law that forbids actions that could bring release from intolerable suffering amounts to torture, and is thus inhumane.

Different protagonists have different ideas about what is at stake in the euthanasia debate. On the side opposing euthanasia, the crux of the matter is often represented as whether killing another human being can ever be tolerated. On the other side, for supporters of euthanasia the crucial issue is whether an individual should be allowed to make decisions regarding their own death. This is the way Fox, et al formulate it:

'Within the context of relatively democratic, urbanised market societies in which individuals must constantly make important decisions regarding every aspect of their lives, they are suddenly prohibited from doing so when it comes to their health – especially, their final life decision: when they want to die' (Fox, et al 2000, p.52).

Indeed, it appears paradoxical that at a time when we are not only allowed but 'obliged to be free' (Rose 1999; see also Giddens 1991), this freedom does then not extend to the manner of our deaths.

Durkheim is the classical sociologist whose insights into questions of the relationships between the individual, society and morality, are often considered the most profound

(Crow 2002). That Durkheim is still of interest for us today can be demonstrated by the light his ideas throw on the euthanasia debate. Durkheim argued that with an increasingly complex division of labour in society, different and often opposing moral ideas and interests would develop. With regard to euthanasia, we can see particular moral ideas linked with particular professional groups, but also within those groups there are contrary and even opposing beliefs. While holding that the division of labour is fostering the diversification of moral ideas, Durkheim also argues that society needs a common morality to hold it together:

‘Whilst commanding men to specialise, it [public opinion] has always seemingly the fear that they will do so to excess. [...] Generally speaking, the maxim that decrees that we should specialise is as if refuted everywhere by its opposite, which bids us all to realise the same ideal, one that is far from having lost all authority’ (Durkheim 1991, p.5).

In Durkheim’s view, the division of labour becomes the predominant source of social solidarity and the foundation of the moral order. He argues that

‘Being more mobile, the individual changes his environment more easily, leaves his own people to go and live a more autonomous life elsewhere, works out for himself his ideas and sentiments. Doubtless all trace of common consciousness does not vanish because of this. At the very least there will always subsist that cult of the person and individual human dignity [...], which today is already the rallying-point for so many minds’ (Durkheim 1991, p.333).

What Durkheim said over a hundred years ago appears to be strikingly relevant to the euthanasia debates today. First of all, euthanasia supporters argue their case from the position of the individual and her wishes. Opponents hold that killing has always been and should always be forbidden, upholding a long tradition. Following Durkheim, the cult of the individual (what he calls ‘moral individualism’) would eventually displace tradition. While this has happened in many spheres of life, the taboo on killing has been

very resistant (there are clear historical reasons for this, such as, the traumatic events of the Nazi regime and the responses to them in the aftermath of the Second World War). Does this mean that the legalisation of euthanasia is only a matter of time? Not necessarily, for Durkheim himself gives us the reason for this. He holds that because the collective consciousness is increasingly reduced to the cult of the individual,

‘[...] the characteristic of morality in organised societies [...] is that it possesses something more human, and consequently more rational, about it. It does not cause our activity to depend upon ends that do not directly concern us. It does not make us the servants of some ideal powers who follow their own course without heeding the interests of men. It requires us only to be charitable and just towards our fellow-men [...]. The rules constituting this morality have no constraining power preventing their being fully examined. Because they are better made for us and, in a certain sense, by us, we are freer in relation to them. We seek to understand them and are less afraid to change them. [...] But it is important that it should open up for our activity a long-term perspective – and such an ideal is far from being on the point of realisation’ (Durkheim 1991, p.338/339).

There is, then, a difference between evoking individual dignity as a rhetorical strategy in an argument that supports euthanasia, and thinking about individual dignity as the starting point of our deliberations about whether we should allow euthanasia, legalise it, erect clear rules about it or allow it to go on out of sight. According to Durkheim, the freedom of the individual can never mean autonomy from society. He insists that ‘liberty (by which we mean a just liberty, one for which society is duty bound to enforce respect) is itself the product of a set of rules’ (Durkheim 1991, p.xxxiii). From his position, to argue in favour of euthanasia on the basis of the freedom of the individual alone is not enough. There is always more that has to be taken into account.

While on the one hand ‘thou shalt not kill’ is opposed by the belief that the individual must be allowed to decide for herself, a lot of the euthanasia debate is about establishing the ground for being able to say what the consequences of the legalisation of euthanasia

would be for society as a whole and the individuals that form part of it, and on the basis of that to decide on a strategy in relation to euthanasia: regulate, legislate, or not.

The main aim of this thesis

In Britain, as well as most of the rest of the world, euthanasia is illegal. However, opinion polls have registered increasing public support for euthanasia, which now stands at over 80%¹. Support for euthanasia by doctors and nurses is smaller, but nevertheless almost half of them view it favourably². This obvious discrepancy between the law and public opinion led to a House of Lords Select Committee on Medical Ethics to discuss euthanasia. In 1994 the Committee recommended that the law on euthanasia remain unchanged (Walton, 1995a and 1995b; Walton Report, 1998). Similarly, the discrepancy between codified medical ethics which forbids killing, and the views of a large number of doctors and nurses, triggered the BMA Physician Assisted Suicide Conference Project on the Internet with the intent to get a broad range of people involved in setting the agenda for a consensus conference. This conference, held in 2000, could not agree to recommend a change in the law to allow physician assisted suicide (BMA 2000). The rift between public moral sentiment on the one hand and legal codes and medical ethics on the other thus remains unchanged.

It is the unresolved issue of that continuing rift between the medical and legal establishment and public moral sentiment which provides the starting point for this thesis. The guiding principle of this study is to further our understanding of why we are at this point, and what could help bring about some kind of resolution. Much of the present debate about euthanasia goes on reciprocally in the media, particularly newspapers, as well as among experts of different kinds – philosophers, lawyers, doctors, and so on. The main aim of this thesis is to explore how the concept of euthanasia is represented in these

¹ 82% in 1994 agree that ‘doctors should be allowed by law to end the patient’s life’ if someone with a ‘painful incurable disease’ makes such a request (compared with 75% 10 years earlier) (Seale 1997).

² In a survey of over 750 GPs and hospital doctors, 46% agree that ‘doctors should be legally permitted to actively intervene to end the life of a terminally ill patient where the patient, when mentally competent, has made a witnessed request for euthanasia’ (BMA news review, September 1996). Out of 1000 nurses responding to a questionnaire in Nursing Times, 49% thought that a doctor would be justified in prescribing a lethal dose of drugs for a patient in the final stages of terminal cancer and in great pain (Nursing Times, August 1998).

debates, both as an expression and formative influence on public consciousness and sentiment.

'Euthanasia' as a contested concept

'Euthanasia' is a complex and contested concept. It does not refer to a recognised legal category or medical procedure, nor to a specific action or set of actions; rather it is a relational concept which, like 'palliative care', refers to the expectation of bringing about a change in another's physical state. In this case, the state of change is death. However, it is distinguished from other forms of killing – murder, manslaughter, accidental death – by both the circumstances and the motives and intentions that are typically invoked. Thus, 'euthanasia' is commonly described as the compassionate killing of a terminally ill person who is in unbearable pain or distress.

Even this description can be contested, for instance, by the argument that there is no such thing as '*compassionate* killing'. Yet, interested groups who want to debate euthanasia have to start with some definition. The BMA Physician Assisted Suicide Conference Project on the Internet, started with the following definition: 'Euthanasia is a deliberate act or omission whose primary intention is to end another's life'. However, this basic definition is not universally accepted, as it can be argued that omissions are to be considered to be something other than 'euthanasia'.

So far, we have talked about the 'establishment' of a category of 'euthanasia' (a *concept* of euthanasia). There is a second process which has to be distinguished. This is the 'assignment' of categories (Bowker and Star, 1999). Even if we have an agreement over what 'euthanasia' means (that is, over the concept that the word 'euthanasia' refers to), once we are confronted with a case or act, it is by no means certain whether this case will be described as an act of 'euthanasia'. For example, a doctor gives a large dose of morphine to a patient who subsequently dies. Was this a death by 'euthanasia' or not? Was it a deliberate act with the primary intention to end another's life? It is easier to arrive at an agreement when all concerned agree on the definition – which can to a certain extent be compared to what has actually happened. It gets very complicated indeed if people are using the same word – 'euthanasia' – but mean different things by it, that is,

they are starting from different definitions of the concept. Another example would be switching off a ventilator that a person's life depends on. Is that an act of 'euthanasia' or simply a 'withdrawal of treatment'? The House of Lords Select Committee on Medical Ethics in 1994 put down in their report that it would be the second. The aim of a Committee like this one is to negotiate some kind of consent and establish a definition that ideally everybody who henceforth discusses 'euthanasia' agrees upon. However, it must be said that the issue is by no means decided; for clearly the BMA definition above includes switching off a ventilator, if it is defined as a 'deliberate act with the primary intention to end another's life', under its definition of what should be called 'euthanasia'. Hence there are disagreements over how euthanasia should be defined, and differences of opinion on what any given definition should include.

Choice of data

From what has been said above it should have become clear that it is not self-evident what people – experts, the public – mean when they refer to 'euthanasia'. Even expert bodies clearly mean different things. The aim of this thesis is to explore these meanings around euthanasia. Much of the debate about euthanasia goes on in the media as well as among experts of different kinds. The media is a broad category, including visual media of television and film (and, as Croteau and Hoynes point out, today 'claims about 'the media' are often [limited to] claims about televised images' (Croteau and Hoynes, 1997)); the medium of the printed word in different forms – newspapers, magazines, books; and the medium of the spoken word through radio. There is a spectrum from more specialist journals aimed at particular groups of professionals: academic journals, doctors' and nurses' magazines, and so on, to mass popular newspapers. With the expansion of the Internet and cheap publishing facilities on home computers, output aimed at ever more specialist audiences has proliferated. Expert and mass media are not however wholly separate categories; in fact, the mass media to a greater or lesser extent draw on expert opinions, and experts are dependent on the mass media to communicate their views. To a certain extent, the distinction between 'expert discourse' and 'media discourse' is constructed. An understanding of expert discourses is vital before looking at

euthanasia in the mass media, precisely because of the flow of ideas between experts and that media. This is why Chapter (4) looks in detail at expert discourses on euthanasia. However, the main part of the thesis is devoted to exploring media representations of euthanasia. The medium chosen is the printed word in newspapers, for several reasons:

1. Newspapers are aimed at large and diverse audiences: choosing a sample that includes national and regional newspapers gives access to a diversity of events represented in newspapers relating to euthanasia (including local ones that never appear on national television);
2. Newspapers rely on the printed word as do expert discourses;
3. There is no evidence that public consciousness and sentiment towards euthanasia as expressed in newspapers is any different from consciousness and sentiment expressed on television or radio.

Regarding point 3., it has to be stressed that I do not argue that newspapers are not in some way different from other media genres. The difference between genres is a major topic within media studies (see Stewart et al, 2001; or Reah, 1998). Genre refers to the classification of media texts into groups with similar characteristics; texts that fall within a particular genre adhere to certain conventions and are based on a formula that writers (or producers) follow and readers (or viewers) expect. Newspapers, for example, adhere to realism: ‘realism [...] is the process by which the dominant experience of daily reality (in terms of what our lives look and sound like, the common narratives and ideological perspective they contain) is reproduced in our media representations’ (Stewart et al 2001, p.168). We are then not looking at the difference between fact and fiction, because also fictitious television programmes are often set within the realist mode; indeed, as Stewart et al argue, realism is the ‘dominant mode of representation, realism is taken for granted and rarely considered and it might be easier to explain what it is *not*’ (italics in the original) (Stewart et al 2001, p.168/169). Media genres might then differ in their conventions of how they present particular issues (differing in the depth of coverage, or in the balance between fact and fiction and the extent of adherence to the realist mode), however that is no contradiction to the assumption that the underlying consciousness or

sentiment regarding an issue like euthanasia is expressed no differently within different media genres dealing with the same issue.

I would like to clarify this view with an example: Friedrichs and Vogt (1996) is a collection of case studies of different German magazines and their representation of religion. Some magazines are directed at a specialist audience (woman, young people, managers), others try to reach a broader audience of generally politically and socially interested people. The portrayal of religion differs in details according to which audience a magazine directs itself towards: for example, in a feminist magazine, organised religion always goes hand in hand with the subordination of women, whereas in a magazine for women which tries to combine the traditional with the progressive in women's lifestyles, the churches are not generally dismissed but called upon to cater more closely to contemporary women's needs. However, if one wants to take the portrayal of religion in magazines as an indicator of the contemporary public consciousness of the cultural phenomenon of religion in German or Western society, one can find that the magazines' portrayals have more in common than not: secularisation, individualisation and privatisation, as well as the transformation of institutionally given rules into abstracted values and binding norms of solidarity and ethical living, are processes apparent in all magazines. Religion has first and foremost become the decision of individuals, and in the light of the functional shifts in the understanding of religion (away from the organised churches), it is also possible to derive from the magazines' portrayals a re-sacralisation ('Resakralisierung') of specific areas of life and life forms, such as the family, love, or autonomy. What one can observe is a process of diffusion of religion (religion does not disappear in the magazines), but on the contrary, religious phenomena are actually broadening out, their boundaries are expanding. It is likely that looking at other media genres (newspapers, television, and so on), there will be differences in the details of the portrayal of religion (according to the conventions of genre, the restrictions of the production process, the target audience), but also, that there will be no difference in the underlying public sentiment on the cultural phenomena of religion in contemporary society. If a study, like my study of media representations of euthanasia, is directed towards that second area of interest, then one can assume that it becomes largely irrelevant which type of media is chosen. To minimise the possibility that a minority

view might distort results, newspapers were chosen as data for the reason that they attract large and diverse audiences – which makes them most likely to be representative of public sentiment as a whole.

Because the interest of this thesis lies in contemporary representations of euthanasia, a sample was chosen that represented British newspaper coverage of euthanasia for the 12 months closest to the time of the research available on LexisNexis. The selection of newspaper articles was done on the basis of the presence of the word ‘euthanasia’ in the text, as that provided access to material which could reasonably be believed to hold information on the conceptualisation of meanings around ‘euthanasia’ in the press (for a discussion of LexisNexis and the sampling process, see Chapter (3)). However, rather more has to be said on how media representations are conceptualised in this thesis.

‘Representation’ as the collective representation of meaning

‘Euthanasia’ is a concept whose meaning is contested. It does not refer to a particular action, but to an idea. Those who use the word and debate its definition and meaning, discuss a concept and only incidentally particular actions. The debate about ‘euthanasia’ is first and foremost a debate about a concept – about its meaning and application. This thesis is interested in the ‘euthanasia debate’, and thus the meanings attributed to the concept of ‘euthanasia’. Its focus is the investigation of how the concept is used in the media; that is, it deals with media representations of the *concept* of ‘euthanasia’. The concept of ‘euthanasia’ is being employed within different social spheres, both in and beyond the media. This thesis is concerned with the ‘collective representation’ of ‘euthanasia’ - ‘collective representation’ being a term used by Durkheim to convey the idea that concepts are a collective accomplishment. Media content is here understood to be a site where the concept of ‘euthanasia’ as a collective representation can be observed.

Throughout this thesis, the term ‘representation’ will be employed to refer to the socially emergent meaning of concepts – it would be quite mistaken (which should indeed have become clear from the discussion above) to understand it as referring to things, events, actions as such (in terms of an unrefined realism). The entry for ‘representation’ in the Dictionary of Sociology (Marshall 1998) begins by stating:

‘Representation refers to the way in which images and texts reconstruct, rather than reflect, the *original sources* they represent. Thus a painting, photograph, or written text about a tree is never an actual tree, but the reconstruction of what it seemed to be or *meant* to the person who represented it’ (my italics) (Marshall 1998, p.565).

Representation has thus to be understood as the reconstruction of meaning – meaning being the original source, not the tree itself. This thesis was guided by Howard Becker’s simple but effective definition of representation as ‘the ways human beings have developed for telling others what they think they know’ (Becker 2000), thus combining the construction and communication of knowledge and beliefs – that is, the construction and communication of meaning.

Situating the study of media representations of euthanasia

This thesis is first and foremost situated within the large and ever more diverse field of sociology. The one thing that still unites sociology with its different approaches (‘sociologies’ (Urry 2000)) is that a study has to start with a problem. This thesis starts from the problem of understanding the rift between the medical and legal establishment and public moral sentiment on euthanasia. The data was chosen on the basis of its potential for shedding light on the problem at hand. In approaching the problem, the study draws (where appropriate) on the theoretical perspectives of classical sociology (the work of Durkheim 1991, Weber 1964), contemporary sociology (Barnes 2000, Baumann 1995, Crow 2002), and poststructural and postmodern social theory, including literary theory (Doyle McCarthy 1996, Culler 2000).

In terms of methodology, the study (being a study of texts) employs ideas from discourse analysis as well as more generally textual analysis. ‘Discourse’ is a term that is operationalised in different research traditions to mean different things. One version of discourse analysis comes out of literary studies and the study of language, such as, Fowler’s (1991) approach to language in the news. Another one was developed by social psychologists (Gilbert and Mulkay 1984, Potter et al 1990, Potter and Wetherell 1994 and

1997, Billig 1989 on rhetorical analysis) to investigate how language constructs notions of the social world and how it is employed to 'get things done' (Potter and Wetherell 1994, p.32) in social interaction, both direct interaction and interaction mediated by texts. A third one, initiated by Foucault and developed ever since within sociology (Prior 1997, Tonkiss 1998), looks at texts for evidence of particular ways of structuring areas of knowledge and social practice. What the different traditions of 'discourse analysis' have in common is the idea that 'discourse' structures meaning. An interest in 'discourse' is an interest in the meaning conveyed by language. A more detailed description of the varieties of 'discourse analysis' and my application of them can be found in Chapter (3).

Textual analysis is associated with cultural theory and draws on poststructuralist understandings of meaning. Many sociologists today (after what has been called the cultural or linguistic turn in sociology (see Bonnell and Hunt (eds) 1999)) work within and are incremental in developing this tradition (Silverman 1993, Alasuutari 1995). One area that is being developed within this tradition is narrative analysis (Berger 1997, Lieblich et al 1998), which is an important perspective for looking at newspaper texts which are telling stories.

This study of media representations of euthanasia is thus a *study of the representation of the meaning of 'euthanasia' in discourse*, where 'discourse' refers to 'structures of meaning expressed in language'. The way 'discourse' is employed here can refer to structures of meaning relating to a particular topic ('euthanasia discourse'), structures of meaning relating to a particular way of framing an issue ('voluntary euthanasia discourse', 'terminal illness discourse'), or structures of meaning relating to a particular medium ('newspaper discourse') or a particular group of people ('expert discourse'). The term 'discourse' as employed in this thesis is thus not given meaning by any one particular version of 'discourse analysis'. The thesis draws on the insights of discourse analysis and textual analysis, and narrative analysis. How these techniques are employed will be discussed in more detail in Chapter (3).

While the substantial topic of this thesis is 'euthanasia', this study should not be confused with a study of the *practice* of euthanasia. Direct research of the practice of euthanasia has so far only really been possible in the Netherlands, where euthanasia is practised openly in the context of decriminalisation (see Pool 2000). In Britain, research

into the practice of euthanasia has so far only been done in an indirect way by Tate and Ward (1994) who asked doctors about their attitudes to competent patients' requests for euthanasia in order to estimate the proportion of doctors who have taken active steps to hasten a patient's death. Social research in Britain is generally confined to the exploration of public and professional attitudes to euthanasia (see Donnison and Bryson, 1996), Tate and Ward (1994) and related issues such as research into the reasons behind requests for euthanasia (Seale and Addington-Hall, 1994).

The study of media representations of euthanasia also has to be situated in relation to the every growing field of media studies. This study is not simply an exercise in media or communication studies. It is conceived as a sociological study starting from a problem, with the choice of data and analysis directed towards that problem. In media studies, the first orientation is towards media theory, whose interest lies in furthering knowledge on how the media produce cultural commodities and how those commodities are consumed. In fact, according to Louw (2001), trends can be discerned within media studies that can be described according to whether the emphasis lies with issues of production or consumption: he claims that the earlier central concern with 'the encoding dimension of the communicative process' with 'too great a focus on communicators and the medium/media' led to a shift towards the 'decoding dimension and 'active audience'', which he sees as simply 'another lopsided understanding of the communication process – instead of over-emphasising encoding, decoding was now emphasised' (Louw 2001, p.vii). Louw himself advocates the understanding of communication as a 'total process' involving 'a concern with both encoding and decoding' (ibid.). These issues are important for media studies, because they lie at the heart of what media studies are about: understanding how and why the media produce particular cultural meanings. My study, by contrast, is not concerned with how and why the structures of meaning around euthanasia are produced in the media, or what exactly audiences make of them. In my study, media representations of euthanasia are approached in terms of cultural representations of a concept. Chapter (2) presents a personal narrative of how I arrived at this approach and its relationship to media studies.

Having established that this study is neither one of media production nor one of media consumption, I want to discuss how it is related to studies of media content. Studies of

media content fall between media studies, communication studies, cultural studies and sociology. Approaches to the analysis of media content range from quantitative content analysis, to qualitative textual analysis based on poststructural understandings on meaning (Lupton 1999). There have been virtually no studies of euthanasia as represented by the media (see p.59), falling into the first or the second category. Euthanasia today is often seen as a medical issue, and there have been a large number of studies of health, illness and medicine in the media (see Lupton 1999, Seale forthcoming). A number of them exclusively investigate newspapers, some in the content analysis tradition (Seale 2001, Freimuth et al 1984), others in the qualitative analysis tradition (Lupton 1994, Gwyn 1999). Some studies go beyond looking at content to include issues of production and/or consumption (Henderson and Kitzinger 1999, Lupton and Chapman 1995), but many are concerned exclusively with content (see above). The important thing to note is that all those studies look at media content with different objectives in mind: the understanding of discourses within the texts (conceived of as resources that people can draw on) around a particular topic in the media (Gwyn 1999 on 'killer bug disease'); the understanding of wider discourses (beyond the texts) on issues like femininity and responsibility by looking at how one particular topic is presented by the media (Lupton 1994 on breast cancer); or an understanding the whole process from the production of the media coverage of a particular issue to its consumption (Henderson and Kitzinger 1999). This means that not only are there different methodological approaches to analysing media texts (from quantitative to qualitative), but just as important are the theoretical context and the theoretical objectives that a study of media content aims to achieve.

The theoretical context of my study of media representations is thus as follows. It starts with the research question: how does the media represent 'euthanasia'? The meanings given to the concept of 'euthanasia' are embedded within particular discourses that can be found within media content. In particular, this study focuses on the investigation of newspaper texts, for the reasons given above. The methods employed in order to answer the research question are based on techniques derived from the different approaches of discourse, textual and narrative analysis. It is explicitly acknowledged in the thesis that the sentiments, interests and moral intuitions expressed in these newspaper

texts are constructed according to a number of interests (social, political, economic, historical). However, as they appear to us we can take them as 'given' in the sense that they exist, they are accessible, and they thus play their part in the contested meaning embedded in the concept of 'euthanasia' which we collectively construct. According to Durkheim,

'It is impossible for offences against the most fundamental of the collective sentiments to be tolerated without society disintegrating' (Durkheim 1991, p.330)

The question then must be: what are those most fundamental collective sentiments? Opponents of euthanasia tend to hold that the most fundamental sentiment is that we should not kill each other. If this fundamental sentiment is not only violated, but in addition sanctioned by the law, they fear that social solidarity will suffer, with society becoming dehumanised. However, the fact that a large proportion of the population expresses support for euthanasia points towards a moral change away from that position. The media can be approached as a site where expert and lay discourses meet. Also, the media can be seen as being both influenced by and influencing public opinion (Croteau and Hoynes (1997, p.161)). On both counts it appears that taking a close look at the media can give us a different perspective on the fundamental collective sentiments that form the basis of contemporary moral ideas about euthanasia.

Where I, the researcher, am coming from

I am German and my academic background is in sociology, social anthropology and Spanish. I was therefore able to follow some of the euthanasia debate in German and Spanish, and not just in English newspapers. This allowed me to get a broader overview over the topic than I would have been able to if I could only read English, which arguably added to my sensitivity on the role of language in the euthanasia debate. I first got interested in end-of-life issue while working as a volunteer for a couple of hours a week in the Pilgrims Hospice in Canterbury, and for two months in the summer of 1997 full-time in the Hospiz, Stuttgart, Germany. In 1997/98, I did an MA in Sociology by

Research and Thesis at the University of Kent on ‘The Shifting Boundaries of Nature and Culture: Implications for Contemporary Social Thought’ which was a theoretical and library-based project, therefore my previous experience and interest has been more theoretical than empirical.

The PhD project was originally based on a research proposal devised by my supervisors Prof Clive Seale and Dr Mike Michael, who secured a PhD Studentship in ‘Psychosocial Research and Education’ from the Cancer Research Campaign (now Cancer Research UK). The stated aim was to discover the ways in which ‘euthanasia’ is portrayed in various media, using discourse analysis. The original proposal did not start from a problem, that is any reason for why we would want to know about how the media portrays euthanasia – which in my view is the essential starting point for a thesis in sociology. Initially, I devoted myself to learning about my substantial topic, euthanasia, which meant reading and watching anything and everything to do with euthanasia (professional, scientific, news and broadcast media in the realist mode, but also fictitious accounts like novels and films³), until I felt I had an understanding of the topic. Also, I had to familiarise myself with media studies and different types of analysis and methodologies. In the course of developing my theoretical framework (as laid out above), I decided to limit my sample to newspaper coverage of euthanasia, as that appeared appropriate for achieving my theoretical objectives (exploring the meanings given to the concept of ‘euthanasia’ as expressed in the media, as both an expression and a formative influence on public consciousness and sentiment). A comparison between professional, scientific and general media developed into exploring the concept of ‘euthanasia’ in expert as well as media discourse.

The three authors that have most influenced my thinking were Barry Barnes on ‘Understanding Agency’ (2000), helping me to think about the notions of ‘agency’, ‘freedom’ and ‘choice’; Howard Becker and his book ‘Tricks of the Trade’ (1998), with

³ As Croteau and Hoynes say, ‘we conventionally organise media according to how closely they represent reality. We talk, for example, about fiction versus non-fiction, news or public affairs versus entertainment, documentaries versus feature films, and so on’ (Croteau and Hoynes 1997, p.134). In fact, there is sliding scale of how far any one media product diverges from the real world – even media products in the realist mode construct the world in a particular way as they re-present it. There is no reason why the portrayals of euthanasia in the more realist mode should have a larger influence on public moral consciousness and sentiment than more semi-fictional or fictional portrayals. Therefore, from my point of view, any contemporary portrayal of euthanasia was interesting.

its appropriate subtitle of ‘how to think about your research while you’re doing it’; and Michael Billig’s work on categorisation and particularisation in his book ‘Arguing and Thinking’ (1996) as well as his ideas on scholarship and methodology (1988).

Clive Seale who has an interest and knowledge in the sociology of health and illness, death and dying, the hospice movement, euthanasia, old age, and more recently the media, advised me on issues to do with my substantial topic, euthanasia, as well as the media. Mike Michael with his background in the sociology of science and technology, the public understanding of science and post-structuralist social psychology, guided me in questions of methodology, that is discourse, rhetorical and generally textual analysis. The sociology department at Goldsmiths College has a distinctive emphasis upon theory and qualitative analysis, which combined with my previous interests on the shifting boundaries between nature and culture has led to the development of my research and the thesis as it now stands.

The organisation of the thesis

Chapter (2) argues why it is important to look at the media and advances a perspective on how to conceptualise the media in society to develop the understanding of media representations as cultural representations which informs this study.

Chapter (3) discusses methodology by presenting different ways of analysing texts: content analysis, discourse analysis and narrative analysis. It then goes on to giving an account of the methods used in this study.

Chapter (4) presents a brief review of the literature available on euthanasia, before examining the state of expert debates on euthanasia, which are today predominantly philosophical/ethical and medical in character.

Chapters (5) to (8) are the chapters based on the empirical work on the way euthanasia is portrayed in the 12 months of British newspaper coverage from November 1998 to October 1999. Chapter (5) explores the stories about euthanasia that have appeared in the press; Chapter (6) looks at one story in greater detail (the Dr Moor case); Chapter (7) identifies and investigates the ‘voluntary euthanasia discourse’ and the ‘terminal illness discourse’ that structure press discourse on euthanasia; and Chapter (8) considers the way

euthanasia is represented in the contemporary context of an increasingly global world of nations.

Chapter (9) concludes that there is indeed a distinct press discourse on euthanasia, and discusses its implications.

Chapter (2) – Conceptualising the study of media representations of euthanasia

Introduction

This chapter argues that the media provides an important source of access and insight into public consciousness and sentiment on euthanasia. Throughout the chapter, the perspective informing this study will be developed to clarify an understanding of media representations as cultural representations, in the tradition of Durkheim's 'collective representations'.

Opinion polls and the media

So far, very few studies (see Chapter (3)) have been undertaken on how the media report on euthanasia. This alone could make a study of euthanasia in the media worthwhile. I will begin by explaining why one should study media representations of euthanasia, before proceeding to a discussion of the media in society.

My first premise is that the interest of this study lies in the meaning given to euthanasia that forms part of public consciousness on the issue. These meanings can be accessed in public discourse, which I take to include all the debates and arguments on the topic that can be found in the public domain. This public discourse can be meaningfully divided into several distinct parts, for example, medical discourse, legal discourse, philosophical discourse¹. Discourses are connected with practices – medical practice and practices of professional medical associations, for example, or academic practices and institutional contexts. Discourses occur within particular institutions and traditions, and they have different weight and authority in society, depending on the relative power of these institutions. In addition to 'expert' discourses, public discourse also consists of lay discourses, based on viewpoints and opinions held by 'non-experts'.

¹ Classifications never just 'are', they are always being developed for a particular purpose. Different purposes call for different classifications.

Public opinion polls are the method commonly used to capture these public views and opinions. They can be aimed at the ‘general public’ (a representative sample of the population of a particular society) or particular publics, like doctors, patients or relatives of patients.

Public opinion polls are a means of reducing complex arguments into simple questions that can be answered with ‘yes’/ ‘no’ / ‘don’t know’ or ‘maybe’. The results of public opinion polls are generally presented in terms of percentages. For example, in British Social Attitudes (13th Report, 1994), it is claimed that 82% of the British population agree that ‘doctors should be allowed by law to end the patient’s life’ if someone with a ‘painful incurable disease’ makes such a request (compared with 75% ten years earlier). The same report also notes differences in support (in numerical terms) for euthanasia in different situations, for example 80% agreeing that ‘euthanasia should ‘definitely’ or ‘probably’ be allowed by law for a person who has an incurable and painful illness from which he will die, for example, someone dying from cancer’; as opposed to only 42% agreeing that ‘euthanasia should ‘definitely’ or ‘probably’ be allowed by law for a person with an incurable and painful illness from which they will not die, for example, someone with severe arthritis’ (reported in Seale, 1997, and Donnellan et al, 1997).

Here, the numbers are seen to be changing over time and in relation to different situations which surely tells us something – but it is by no means obvious what it tells us, some work of interpretation needs to be done. My main critique of opinion polls is that they appear to be democratic (as we will see below), in that they give equal weight to ordinary people’s opinions. However, what they really do is to translate snippets of opinions into a form that can itself be used as evidence of or support for a particular argument. This form is derived from what (and how) the researcher thinks (embedded as he or she generally is herself in different institutions with particular purposes) – which from devising the questions to interpreting the answers influences every aspect of the study; and not just from what (and how) people think about particular issues.

‘Public opinion’ has a particular meaning and status today. The determination of (general) ‘public opinion’ on all sorts of issues, including euthanasia, is an ever present part of social life: ‘the activity of politics, of advertising, of marketing, indeed public debate itself seems unimaginable without reference to public opinion’ (Osborne and Rose

1999, p.370/371). Osborne and Rose in their article 'Do the social sciences create phenomena?: the example of public opinion research' (1999) argue that the concept of 'public opinion' appears as a self-evident reality, but it has a history that only gradually made it into what we now take it to be. In 1828, 'public opinion was the attribute only of those qualified to have opinions':

'Public opinion may be said to be that sentiment on any given subject which is entertained by the best informed, most intelligent, and most moral persons in the community, which is gradually spread and adopted by nearly all persons of any education or proper feeling in a civilised state' (the 19th century American political thinker William Mackinnon quoted in Osborne and Rose 1999, p.374).

Gradually, the concept of public opinion became democratised, it became 'the aggregate of the opinions of individuals' (Osborne and Rose 1999, p.376). The technique of the opinion poll was developed to capture those opinions. The existence of an objective public opinion that can be accessed and represented faithfully (as the 'truth') has become naturalised and internalised, and public opinion is now being sought for in all kinds of organised social activities. However, another view is that

'public opinion is created by the procedures that are established to 'discover' it. The phenomenon of opinion is an artefact of the technical procedures that are designed to capture it. It is determined by *technical* considerations: for example, the assumptions that go into the construction of a representative sample' (Osborne and Rose 1999, p.382).

In other words, public opinion is constructed just as any kind of knowledge is constructed, but subtly manages to disguise its origins and has come to represent an objective 'truth'. The varying organised activities that determine public opinion in today's societies are in themselves permanent confirmations of its existence and validity:

‘public opinion is something that is demanded by the very activity of asking questions in surveys. That is, the existence of questionnaires and surveys *themselves* promote the idea that there is a public opinion ‘out there’ to be had and measured. They invite respondents to measure their own responses in relation to the existence of such an objective field of opinion. And this idea is actually of a rather self-fulfilling sort; we are asked a question, we respond, partly in the light of what we project to be the responses of others, and, in doing so, we actually contribute to the establishment of the objective field called public opinion’ (Osborne and Rose 1999, p.387).

From the above discussion we can see that ‘public opinion’ is a form of knowledge particular if not peculiar to our society today. Public opinion thus exemplifies Thomas’ famous axiom which states that in social life, what people take to be real is real in its consequences (Berger 1966, p.100). We believe in public opinion. We (individually and institutionally) act in response to it. Public opinion is important – even if we are aware of its constructed nature.

This leads me to a discussion of the limitations of public opinion polls (general and particular) to explain my interest in media representations.

Public opinion polls consist of carefully crafted questions devised by researchers and developed to elicit specific responses to particular problems. The responses are often presented in numerical form, for example giving the percentage of respondents who hold one particular opinion as opposed to another one, or other ones. The way the problem is posed and the questions asked both bear the mark of the researcher. The respondent has to fit his or her answers within that given structure. This is a useful strategy if one knows what the question is and what kind of answer one wants or needs (for example, in commissioned research that has a particular purpose). However, if one is interested in public opinion on a topic like euthanasia, it becomes clear that the researcher relies heavily on the given structures of thinking and arguing this issue – both using it and contributing to it. If the interest lies precisely in exploring those structures of thinking and arguing, then interest has to shift from what the respondents answer to what and how the researcher asks. Especially with euthanasia, it is obvious that responses vary greatly

depending on who is conducting the survey – surveys commissioned by organisations with an interest in the legalisation of euthanasia tend to show higher support for the practice than surveys conducted by organisations linked to hospice².

Surveys often rely to a great extent on expert opinion, both in the kind of questions they ask, and the way they are asked - but experts are not above particular interests themselves.

The reason why a study of the media could be potentially fruitful - if one is interested in the structures of thinking and arguing about euthanasia - is that in contrast to the carefully worded surveys that bear the mark of the researcher, the media represent what I will call for the moment ‘naturally occurring’ data. Let me explain what I mean by that. The media themselves are in no way ‘natural’. They are social institutions with particular interests, rules and constraints. What gets into the papers is decided by editors, who often claim to be responding to the public interest (‘that’s what people want to read about’). Articles are written by individual journalists with their particular affiliations and areas of expertise. Studies of media production in general address those things: how is it decided what gets into the news? Why do journalists present an issue in this particular way and not that?³ In contrast, what I propose to do is a study of media representations: to take newspaper articles on euthanasia as given, not asking why they present the issue in certain ways, but investigating *how* they present it. The texts themselves are messy, they incorporate many different influences. They make reference to ‘experts’ and claim to represent ‘common sense’. They mix lay and expert discourse and create their own ‘media discourse’. Therefore, they are not ‘natural’ but ‘naturally given’. How they

² To illustrate this: in 1997, a survey conducted by the German Hospice Association (‘Deutsche Hospiz Stiftung’) found that only 42% of the German population were in favour of active euthanasia (Aertztezeitung, 15.4.1997). In 2000, a survey commissioned by the German equivalent of the Voluntary Euthanasia Society (‘Deutsche Gesellschaft fuer Humanes Sterben’) found 81% of the same population to be in favour of active euthanasia (Berliner Zeitung, 6.6.2000). We have the image of a minority versus a large majority of the population to be in favour of euthanasia – a discrepancy that cannot be result of the three years between the surveys.

³ For example, Galtung and Ruge (1964) asked the question: ‘how do ‘events’ become ‘news’?’, developing a definition of ‘newsworthiness’ on the basis of twelve factors and three hypothesis describing the interrelationship of those factors. Schudson (1989) provides an overview of the three perspectives within the sociology of news production: (1) the view of political economy that relates the outcome of the news process to the economic structure of the news organisation; (2) the view that relates the outcome of the news process to the journalist and the constraints posed to him by the social organisation of news production and occupational ideology; and (3) the view that emphasises the constraining force of broad cultural symbolic systems.

present the topic of euthanasia is not a direct response to a specific interest – it is not influenced by the research agenda (if by other agendas specific to the media production process that the researcher should be aware of). The researcher can take the texts as given in the sense that they are produced in a specific way, but not produced according to the researcher's interests, as surveys often are. An analysis of the texts can say something about the way the media treats the issue of euthanasia as well as giving some insight into how the issue might be understood and reciprocally influence society at large. The purpose of a study of media representations is thus to investigate media discourse on euthanasia with the ultimate aim of gaining a wider understanding of the structures of thinking and feeling about euthanasia that may be influential in public discourse and debate (for example, in determining the kinds of questions asked by opinion pollsters).

Media in society

If we can say that media texts are messy, then the relationship between the media and society is just as messy. Before embarking on a study of the media, one has to grapple with two, albeit related, issues: the role of media in social life, and the relationship between media and their audiences.

1. *A social theory of the media*

John Thompson in his book 'The media and modernity' (1995) makes an attempt at a general social theory of the media. In a sense, we are so used to living in a mediated culture that we cannot see the impact the media have on our lives and social consciousness. However, as Thompson argues, we have to appreciate that the development of communication media has brought with it 'a reworking of the symbolic character of social life, a reorganisation of the ways in which information and social content are produced and exchanged in a social world and a restructuring of the ways in which individuals relate to one another and to themselves' (Thompson 1995, p.11).

Thompson holds that what we need today is a theory for an 'age whose broad contours were laid down some while ago, and whose consequences we have yet fully to ascertain' (Thompson 1995, p.9). Before newspapers, radio, television and internet,

'for most people, the sense of the past, the sense of distant places, as well as the sense of the spatially delimited and historically continuous communities to which they belonged, were constituted primarily by oral traditions that were produced and handed down in the social contexts of everyday life. But the increasing availability of mediated symbolic forms has gradually altered the ways in which most people acquire a sense of the past and of the world beyond their immediate milieu'(Thompson 1995, p.33/34).

As Thompson says, 'the role of oral traditions was not eliminated, but these traditions were supplemented, and to some extent reconstituted, by the diffusion of the media' (ibid).

Thompson talks about 'mediated historicity', 'mediated worldliness' and 'mediated sociality' to delineate the different aspects of media influence in social life. In the transmission of historical knowledge,

'parents and teachers [...] come to rely more and more on books, films and television programmes to convey to children the main themes of a religious or other tradition, and [...] see their own role more in terms of elaboration and explication than in terms of the cultivation of tradition from scratch' (Thompson 1995, p.196).

History and tradition are seen as our heritage, but it is a heritage stored in books and films that are the guardians of objective accounts of 'History' and 'Tradition', acquiring an abstract existence outside the individuals who live the histories and traditions of a society. Films and books appear to know more than we do, we go to them to learn about ourselves. Tradition, in classical sociological thought, is believed to decline in significance in modern societies, ceasing to exist or play any meaningful role in the daily lives of most individuals. Thompson tries to show that tradition has not disappeared, but

has changed in a society shaped by the increasing mediation of symbolic content. Symbolic content gets fixed in media products, and thus has become less dependent on ritualised re-enactment. In a sense, tradition has become *deritualised*.

Also, being dependent on mediated forms of communication, traditions become detached from individuals – they become *depersonalised*:

‘tradition acquires a certain autonomy and an authority of its own, as a set of values, beliefs and assumptions which exist and persist independently of the individuals who may be involved in transmitting them from one generation to the next’ (Thompson 1995, p.196).

Lastly, ‘traditions were gradually and partially *delocalised* as they became increasingly dependent on mediated forms of communication for their maintenance and transmission from one generation to the next’ (Thompson 1995, p.197). With respect to the last point, Thompson insists that the fact that traditions are delocalised does not mean that they were ‘deterritorialised: they were refashioned in ways that enabled them to be re-embedded in a multiplicity of locales and reconnected to territorial units that exceed the limits of face-to-face interaction’ (ibid.).

Far from having done away with tradition, the media has been instrumental in re-shaping it. The media are responsible for the reinvention of tradition and the re-mooring of tradition to territorial units of new and various kinds. In short, ‘traditions have become increasingly interwoven with mediated symbolic forms’ (Thompson 1995, p.202).

‘Mediated wordliness’, in Thompson’s phrase, means that

‘our sense of the world which lies beyond the sphere of our personal experience, and our sense of our place in this world, are increasingly shaped by mediated symbolic forms. The diffusion of media products enables us in a certain sense to experience events, observe others and, in general, learn about a world that extends beyond the sphere of our day-to-day encounters’ (Thompson 1995, p.34).

This implies, among other things, that when we visit other places as tourists, ‘our lived experience is often preceded by a set of images and expectations acquired through extended exposure to media products’ (ibid.).

‘Mediated sociality’ refers to the fact that while ‘our sense of belonging derives, to some extent, from a feeling of sharing a common history and a common locale, a common trajectory in time and space’, today ‘we feel ourselves to belong to groups and communities which are constituted in part through the media’ (Thompson 1995, p.35 – based on Anderson’s (1983) concept of imagined communities).

The concepts of ‘mediated historicity’, ‘mediated worldliness’ and ‘mediated sociality’ do a useful service by putting the role of the media in society today into a historical context. Developments in communications technology have already changed the contours of social life to an extent that is difficult for new generations to appreciate, and they will continue to do so. The shifts are large and have happened rapidly. Still, new ways of communication provided by new technologies become ‘naturalised’ very quickly – it is difficult to imagine that things could have been otherwise. Therefore, in a sense, those shifts fall beyond individual consciousness, even though they may be observable, and for that reason they have to be (and can only be) theorised, as Thompson does.

2. Media and audiences

The second, related, issue is the relationship between the media and their audiences. Thompson draws on and brings together a large amount of theoretical work that has been done in sociology to produce his account of how the media intervene in and change social life. The kind of work he draws on has been and is being carried out in the form of empirical research into the relationship between the media and their audiences.

Much research has been initiated into determining so-called media effects: effects that the media might have on their audiences. The first question is whether media messages have any influence on people’s opinions, and by extension public opinion. The second question is what form this influence takes, if there is any. There are basically three views on this: (a), that the media have direct discernible influence on people’s opinions; (b),

that the influence is more indirect or diffuse and hard to pin down; and (c), that media messages have no effect at all (this last one is essentially theoretical).

I will start with the first position: the view that the media have direct influence on people. There are two research traditions within this category: what Seale (forthcoming) calls the 'effects model', and the 'active audience model'. The 'effects model', assumes that media messages will reach the audience in the sense that they were intended by the producers, and studies that follow an experimental design aim to determine the extent of those direct effects – how far communicated messages have been taken on by the audience⁴. The second 'active audience model' still assumes a direct effect of the media on their audiences, but denies that we know what this effect will be⁵. This model holds that the media audience does not consist of passive receivers of media messages, but active consumers of the media (and not just of their explicit messages, but also their implicit assumptions) which they 'read' from their own point of view, life situation and personal preferences which can, but does not have to lead to 'resistant' readings, that is finding messages in articles and programmes that were never intended by the author or producer. Qualitative research in the form of interviews or focus groups are carried out within this tradition to determine the effects that the media has on people's opinions.

To qualify what I have said above, it may be fair to say that the 'active audience model' with its assumption of a sophisticated, selective and differentiated audience already goes some way towards a view that holds that media influence is more indirect than direct. Media messages (explicit and implicit) are filtered through and interact with the opinions and views and world view that a person already holds. Some messages might be taken on and others not, for all kinds of reason. Whatever direct effect the media

⁴ As Abercrombie and Longhurst point out, historically, 'the earliest attempts at investigation of these effects of the media were undertaken from within the mass society or mass culture approach, which was given a particular impetus in this field by the rise of, and use of mass media of communication by fascist and totalitarian governments in the 1920s and 1930s' (Abercrombie and Longhurst 1998, p.4/5). The basic assumption behind this approach as it was developed historically was that the media did have a direct effect on people that could be described and measured. A different approach developing out of this tradition was the 'cultivation approach' by Gerbner in the 1960s. This approach still started from the assumption that the media do have an effect, but its focus had shifted from assuming the direct effect of one individual media message to investigating the long-term effects of 'cumulative exposure' to the media (Abercrombie and Longhurst 1998, p.6).

⁵ See Abercrombie and Longhurst (1998, Chapter (1)) for a more detailed account of the different phases of audience research including the encoding/decoding approach developed by Hall (1980) and the

has on people is very hard to specify – especially considering that it is near impossible empirically to specify the effect that many, recurring media messages have over long periods of time, as opposed to one particular message at a time.

Here I would like to make some reference to a much earlier study that nevertheless is still of interest for us today. It was carried out by C. Wright Mills in America 40 years ago (Mills 1963). At that time, the situation in terms of the development of communication technology was relatively unsophisticated, and as a consequence the concerns of sociologists with regard to the ‘mass media’ (as it was called then) were somewhat different. There was concern that the then emerging mass media would have the power to brainwash people, making it possible for misguided leaders to manipulate whole populations (as, it can be argued, happened to a certain extent in Nazi Germany). In his article ‘Mass media and public opinion’ (1963) Mills describes how he and his colleagues devised a study ‘to find out how opinions change, how [...] people, as members of the public, actually made up their minds’ (Mills 1963, p.587). To cut a long and complex argument short, what they found was that ‘in the last analysis, it is people talking with people, more than people listening to, or reading, or looking at, the mass media that really causes opinions to change’ (Mills 1963, p.590). That does not mean that the media have no role to play, as it was also found that there were so-called opinion leaders that influenced the opinions of other people⁶. Mills wrote,

‘opinion leaders are more exposed to the mass media of communication of all sorts than are the opinion followers. [...]. What seems to happen is that these opinion leaders pick up opinions from the mass media and pass them on to other people in face-to-face communication’ (Mills 1963, p.595).

The way that Mills sees these opinion leaders in their role as media audience is remarkably similar to the ‘active audience model’. He argues that they are not passive receivers of all kinds of media messages but (self-)select the media they are getting

incorporation/resistance paradigm initiated by Morley (1980) – the discussion of which would take me too far away from the argument I am pursuing here.

exposed to in the first place, which means that media reinforce existing opinions rather than enforcing changes of opinion. He holds that media audiences (in general, not just opinion leaders) compare what they read, see and hear in the media with their own personal experience, while insisting that this experience should not be seen as something primary or really direct but instead has to be conceptualised as being ‘mediated and organised in stereotypes’ (Mills 1963, p. 593).

What all this amounts to is the introduction of a new factor into the direct audience – media relationship, which, if what Mills says is correct, is even more important than this relationship: the direct interaction between people. Rather than other people complicating the individual person-as-audience/media relationship, the media can be seen as complicating or intervening in interpersonal relationships. Whether one agrees that this is indeed the case, or holds that it might have been the case when Mills wrote but that in today’s communication-saturated world his findings no longer hold, I would argue that we still have to appreciate that interaction between people has to be considered when thinking about the media and their audiences.

We can say so far that it seems more likely that media effects have to be seen as more indirect than direct, interacting with people’s previous experience as well as intervening in interpersonal relationships⁷.

A different approach to thinking about indirect effects the media might have on their audiences is the idea that the media ‘may not be successful much of the time in telling people what to think, but it is remarkable successful in telling its readers what to think about’ (Cohen (1963) quote in Ferguson 2000, p.232 and Louw 2001, p.viii)⁸. This view is not without its critics, and empirical research has not managed to clarify the issue (see Ferguson 2000, p.232ff), yet still it is an interesting point if one considers not just the

⁶ The role and importance of opinion leaders had actually already been shown earlier by Katz and Lazarsfeld (1955) – it is their study that generally gets quoted today, for example in Curran and Seaton (1997).

⁷ One reaction to this appraisal of the situation is a kind of postmodern capitulation, which is questioning the validity of being able to say anything at all about any direct effect the media has on people. This does not mean that champions of this view hold that the media has no effect at all on people. They only deny that it is ever possible to say what they really are. The book ‘Message received’ edited by Philo (1999) brings together much recent work on the media in which this debate can be followed.

⁸ Curran and Seaton point out that the other side of this is that people will think less about issues that do not receive any coverage in the media: ‘Martin Harrop argues that this negative power of the media – selectively to neglect some ideas - is a critical, little recognised media effect’ (Curran and Seaton 1997, p.275).

media/audience relationship, but the wider impact of the media in social life. People are not just audiences of media, they are also citizens of political entities.

Political entities set their own agendas. These agendas are the result of struggles of different groups for the recognition of particular issues. These issues may rank higher or lower on the political agenda (which of course changes over time) – and it is conceivable that far from reproducing this political agenda, the media play a large role in making certain issues more or less visible, which will have a direct impact on what people believe to be the hierarchy of issues on the political agenda. Only one issue can be the first item on the nightly television news, and only very few issues make it to the first page of a newspaper. If a newspaper places gossip rather than political items on its first page, we can take this to point to a certain alienation of its readers from the political process. In ‘telling readers what to think about’, the press may have a very direct impact on the political agenda itself – and even on the nature of politics if more and more people remove themselves from the processes of political agenda setting by thinking more about gossip than issues to do with the distribution of power.

Ferguson’s book ‘Researching the public opinion environment’ (2000) deals with the theories and methods of public opinion research. She specifies that the audience that the book is written for is twofold: academic and professional. Consequently, she discusses academic theories about the impact of the media, but from a pragmatic point of view of how to do good public opinion research. She says:

‘Academics spend a great deal of time debating whether media have a direct effect, an indirect effect, or no effect at all on audiences [...]. Presidents, prime ministers and corporations, however, rarely ponder such questions. They hold an unwavering belief that media have powerful effects of an indirect and direct nature. Adhering to this conviction, governments and corporations pay hundreds of thousands of dollars to survey research firms, they commission focus groups, and they establish sophisticated media monitoring systems designed to track and analyse media responses to the organisation’s issues. Whereas *governments* monitor the media to obtain feedback on their policies and programs, *corporations* monitor the media to

learn more about the pressures exerted on top-level government officials, and to project the likely consequences of these pressures' (Ferguson 2000, p.51).

We have noted in relation to public opinion (see p. 33 above) that what people believe to be real is real in its consequences. This can also be seen here: governments and corporations take public opinion to be something tangible that they can monitor and act upon. Much more important for this part of my discussion is that they also believe that they can get at public opinion, relatively unproblematically, directly from monitoring the media. And as it is generally agreed that 'the public-media interaction sets the policy agenda' (Ferguson 2000, p.12), all other groups and citizens functioning inside and outside government positions and corporations have to look to the media. In large parts of her book, Ferguson easily equates public opinion and media opinion, assuming that by looking at the media it is possible to get at public opinion. Towards the end of the book, however, she draws attention to a range of studies which show that people believe that media have a greater effect on others than on themselves – which is called the 'third-person effect'. She writes:

'Some variables affecting the third-person effect are education (people with higher levels of education are more likely to overestimate media effects on others), knowledge (people with greater knowledge of a topic are likely to overestimate media effects on others), the level of engagement with the topic (more involved people tend to overestimate the effects of media on others), the nature of the communication (people are especially likely to think that negative political advertisements or defamatory messages will affect others more than themselves), association with other audience members (people are more likely to overestimate the influence of a message on the 'public at large' or on more remote audiences than on individuals in close physical proximity), and perception of source bias (people tend to overestimate the influence of biased sources on audiences)' (Ferguson 2000, p.236/237).

As Ferguson goes on to say, politicians, bureaucrats and chief executives are individuals that fit this description (highly educated, involved, remote from other publics) which may explain why they concentrate on monitoring the media when they claim to want to know about public opinion. One could argue that what they are doing is introducing an opinion loop between government, big business and the media that by claiming to be interested in public opinion, actually exclude it. But that again would assume that the media is completely separate from what people think, which is plainly not the case either. Whilst we cannot equate media and public opinion, we should not see them as something completely separate.

A further dimension has to be added now to the relationship between media and audiences: this relationship is not only complicated by people's personal situation and world view, as well as interpersonal relationships, but also by their beliefs about the media itself and its impact. As we have seen above, at the institutional level, the media have an impact and an influence that is not based on an appreciation of any actual effect that media messages may have on individuals, but on the *belief* that they do have that influence on people's opinions. As social scientists, we clearly have to see that there is a difference between the actual relationship of media to audience, and the role that a belief in media effects plays at an institutional level.

We have seen that the relationship between media and audiences is complex, therefore complicated, hard to describe and even harder to pin down. In the light of this, it appears to be relatively difficult to justify a study of media content on the assumption that it will influence what people think, as long as theories of media effects differ as greatly as they do. However, we know that the media play an (increasingly) large role in contemporary social life (see Thompson), even if we might be hard pressed to specify what that is. Arguments about the role, function and position of media in social life are as much a facet of contemporary life as the media are themselves. Media are self-referential, they talk at least as much about themselves and each other as about events outside themselves. Opinions range from media increasingly becoming our universe (shaping our world, making our world), to them becoming a parallel universe to the one we generally think we live in (replacing our world). In one word, the media are important, and they are and should be an important focus of study.

At this point, I need to recapitulate what has been said so far in this chapter. I have shown why I think opinion polls to be a poor instrument for studying public discourse: they contain too many unquestioned assumptions about that discourse on part of the researcher, which might influence the design of such a study – from the conceptualisation of the problem to the specifics of the questions asked. I have claimed the media to be a site of observation of public discourse and superior to opinion polls and surveys, if one's interest lies in public discourse. Following on from there, I have discussed the role of the media in social life, and the way that the relationship between the media and the public has been conceptualised. I have concluded from this discussion that the relationship between media messages and individuals is complex and that we do not know the impact that media messages have on individuals and, by extension, how they affect public opinion (however constructed this concept may be). Neither can we say that media opinion equals public opinion, although it is interesting that government and corporations seem to think it does and base important policy decisions on media opinion. So the question now is: what is the theoretical basis on which a study of euthanasia in the media would be both important and interesting?

Instead of concentrating on the influence of media messages on people, or presupposing that media opinions equal public opinion, we can start from the assumption that the content of media to a certain extent reflects, or rather shares in, a public discourse on a topic like euthanasia. This approach recognises that the media does not equal public discourse, but that it is one aspect of it, and that it plays a particular role⁹. To that extent, a study of media representations aims to find out how the media represent a particular topic. However, we can go further than that. Because, as we have seen above, the media play a role in individual lives, public discourse and social life, even if we can't specify that role exactly, we can safely assume that media representations are reflections of more than just the conventions and interests of the media. We can think about the content of media, of media representations as a form of cultural representation.

⁹ See Croteau and Hoynes (1997) on how a sociological approach suggests that media content is both cause and effect.

Media representations as cultural representations

A study of media representations has to be contextualised within the framework of the sociology of knowledge. The basic premise of the sociology of knowledge is that reality is socially constituted, or, in Durkheim's words: 'the world exists only in so far as it is represented to us' (Durkheim 1982, p.238). Representation can be understood, following Howard Becker (2000), as the ways human beings have developed for telling others what they think they know – it therefore combines the construction and communication of knowledge. Representation is thus the basis of any public consciousness. Representation is only possible through shared languages (in the wider sense, of systems of signs signifying meaning). The meanings given to the concept of euthanasia are continuously being developed in a public discourse through a shared language. One way of accessing this discourse is by looking at the media, where the public discourse on euthanasia is played out as a media discourse (both differing from and sharing in a public discourse). Thus, the goal of a study of media representations of euthanasia is to find out what kinds of representations the media discourse on euthanasia brings to the public consciousness on euthanasia.

The concept of 'cultural representations' is based in the Durkheimian tradition stressing the importance of collective ideas or representations for social life. This thesis is not about mapping out what different interested groups think about euthanasia or investigating their relative access to the media in terms of influencing production; it is about the particular way in which 'euthanasia' is conceptualised in the media, the structures of arguing and thinking around it, the existence of which surely has a normalising function on how we can and do talk about the issue, in this society and at this particular moment in time.

I will use the concept of cultural representations in a loose way to mean representations in the above sense, which play a part in the culture that takes euthanasia to be a public issue. Cultural representations are ways of talking and thinking about a particular issue, in this case euthanasia. The next chapter will deal in further detail with how a study of media representations of euthanasia is to be conducted, laying out a

qualitative approach to ‘discovery’, rather than coming to the text with fixed ideas of what one is hoping to find.

Advantages and limits of a study of media representations

As has been said earlier, the purpose of this study is to investigate the media discourse on euthanasia with the ultimate aim of gaining a wider understanding of the structures of thinking and arguing about euthanasia that may set the parameters of and provide the concepts for the public discourse on euthanasia outside the media. It has become clear that this thesis addresses the issue of euthanasia through looking at the media, rather than looking at the media by studying the example of euthanasia. There are limits to this kind of study that have to do with a relative neglect of issues to do with the media themselves.

Within media studies, reception and production are important objects of study. This chapter has theorised reception in some detail, because it is of importance to this particular study to understand how the relationship between media and their audiences is to be conceptualised. My study itself however does not investigate the reception of media representations of euthanasia by an audience, an approach which in itself could have led to some interesting findings not without relevance to an understanding of the public discourse on euthanasia, for example finding out whether media representations of euthanasia are endorsed or resisted, by whom and in which circumstances, and so on.

Neither does my study interrogate issues of production – questions as to how the production process influences the eventual media products and the particular media discourse that can be abstracted from the individual texts. As the unresolved issue of euthanasia is embedded in a long-standing debate, groups have formed that carry particular opinions in relation to euthanasia – positive ones with the VES, negative ones with the hospice movement and some church groups, for example. The relative influence of these groups on the representation of euthanasia in the media is not an issue that can be addressed within an approach of media representations as cultural representations. My study focuses upon the texts themselves, while assuming the tension that generally exist in all media production between the praxis of the media as part of the establishment – and as such they are influenced by government and big business - and the partial reality/ideal

of the media as the guardian of democratic societies. In that second sense, government and business are actually dependent upon the media, and both can be seen to be more able to monitor than to influence the media. To reiterate: how exactly the production process influences the texts is not part of what I am trying to find out.

While an understanding of issues of production and reception form a necessary background to a study of media representations, these issues are not the focus of it. A sociological approach to media representations as cultural representations simply has a different theoretical orientation than, say, a political economy approach interested in investigating issues of relative power in terms of the production of meaning, or a media studies approach wanting to find out about the way audiences decode these meanings.

One last thing that has to be addressed is the fact that the study of media representations is a sociological study in the sense that Doyle McCarthy construes sociology:

Sociology's work must be judged *in situ*: its concepts and its insights develop out of and are addressed to the social worlds of its practitioners. Sociologists are not in the business of offering timeless truths. We are neither poets nor metaphysicians. Our discipline is really designed for *situational diagnosis* that allow us better to understand what is going on in the world around us. As sociology of knowledge best demonstrates, the very concepts and models we employ have their origin in real life; they emerge out of a confrontation with the dilemmas of social living and carry with them our conscious and unconscious strivings. At best, we try to understand our own social world by unraveling its special history. But it is always a history taken from our own particular vantage point. Contemporary sociology begins from and returns to our situation, the one for which it was fashioned in the first place (Doyle McCarthy 1999, p.9).

A study of media representations of euthanasia, conceptualised to find out about representations that share in public discourse on euthanasia, will itself be part of that discourse. Euthanasia has become a problem in contemporary society. The problem is how societies should deal with the different demands of terminally ill people who want to

be able to end their lives on their own volition, doctors who want to be able to help them, and doctors who want to have nothing to do with it, other people that are torn between ideas about the sanctity of life and the rights of individuals – including a number of other competing interests. A study of media representations of euthanasia aims in a small way to contribute to the understanding of that long-standing debate.

Conclusion

This chapter has started with a discussion of the disadvantages of opinion polls and surveys in furthering our understanding of public consciousness on euthanasia, arguing that a study of the media would give a better access to the representations influential in that consciousness. A large part of the chapter has been devoted to theorising the role of the media in society, especially the way that the relationship between the media and their audiences must be understood. This situates the study of media representations of euthanasia in the Durkheimian tradition of collective representations, which has a distinct theoretical orientation, differing from the ones advanced within media studies where issues of production and/or reception come to the fore.

The aim of this chapter has been to provide the theoretical background that explains the particular form that this study of media representations of euthanasia takes. The next chapter will deal with methodology and the methods used in carrying out that study.

Chapter (3) – Carrying out the study of euthanasia in the media: methodologies and methods

Introduction

Chapter (2) has established where this study is situated theoretically. The present chapter deals with the various techniques developed for studying texts used in this analysis (content analysis, discourse analysis and narrative analysis), and indicates how their insights are relevant to this study. A section on the methods employed in this study lays out how the data for this study was generated and how this data was analysed. In the last part, an overview is given of the chapters that follow in order to indicate the structure of the thesis as a whole.

Methodologies of studying texts

Different methodologies have developed that inform the study of texts. In the first part of this chapter, I shall introduce content analysis, discourse analysis and narrative analysis. I do not consider these approaches to be mutually exclusive; instead I regard them as the ‘tool kits’ that have provided me with the methods that I have applied.

Content analysis

Content analysis is the classic approach to studying texts. The basic structure of a content analysis is as follows:

1. Start with a research question
2. Decide on a sampling strategy
3. Define the recording unit (individual words, themes, paragraphs...)
4. Construct categories for analysis (the most crucial aspect of content analysis)
5. Test the coding on samples of text and assess reliability

6. Carry out the analysis

(the above is adapted from Robson's 'Real World Research' 1993, pp.272-279).

As we can see, content analysis starts off with a research question. This requires that the researcher has already formulated a question that she poses to the text, which should be answered through the analysis. Content analysis is about documenting the content of a text or texts, and very often is about counting the instances of particular units in terms of the categories developed. This is a highly regulated approach to the study of texts, and does not allow for discovery of elements that have not been taken into consideration in the development of the categories. As Robson states, the most important part of a successful content analysis, one that is valid and can be replicated to yield the same results, lies precisely in the development of the categories.

It could be argued that what in content analysis would be called the development of the categories of analysis, has become the main part of my analysis of media representations of euthanasia. My study has not started with a precise research question, the answer to which would be provided by the text – the research question was put much more widely: 'how does the media represent the issue of euthanasia?'. The research has been conceptualised more as a process of exploration than a search for the answer to a particular question. I am asking: what are the structures of thinking and arguing about euthanasia, as represented in the press? I aim to describe and analyse, rather than simply to count. In a sense, the emphasis has shifted between a conventional content analysis and what I am doing: content analysis has to operationalise categories, my study wants to explore categories. What is only the initial phase in content analysis becomes the main research aim in my analysis.

Discourse analysis

Robson's textbook on methods from 1993 (see above) has very little to say on discourse analysis. In the intervening years until the present, discourse analysis has become increasingly popular. One thing that Robson says, however, still holds true: 'there is little agreement as to its usage' (Robson 1993, p.287).

The term 'discourse' is instrumentalised in different ways in different research traditions. The 'linguistic turn', not only in sociology but in the social sciences as a whole, describes a situation in which more attention is being paid to language within every tradition. The differences lie in the degree of attention that is paid to linguistic detail, and in how language is thought to be related to social or psychological processes. Consequently, 'discourse' can simply refer to the structures inherent in language. It can mean the structure of arguing over a particular topic (the 'discourse' on euthanasia, independent of texts but found in them), or it can mean ways of thinking and knowing that are related to particular institutional practices ('media discourse' as constituted in texts). The various versions of 'discourse analysis' consequently construct their own particular definition of 'discourse'.

In relation to press articles, we could look at the texts from a critical linguistic point of view (see Fowler 1991), analysing the language of the articles with the aim of exposing the ideology inherent in language – raising awareness of the world as it is conceptually created by use of a particular language. 'Discourse analysis' here becomes analysis of language.

A more Foucauldian type of 'discourse analysis' would look for evidence of 'discourses' that are held to be particular ways of structuring areas of knowledge and social practice, within and beyond the texts. For analysts working in the tradition of Foucault, 'discourses' constitute objects, and position people as social subjects. 'Discourses' here are broadly ways of talking about particular topics and people that structure what can and cannot be said or done¹. 'Discourses' are understood to structure not just texts (in the narrow meaning of words on paper or computer screen) but relations in social life.

For social psychologists Potter and Wetherell (1994, and Potter et al 1990), 'discourse analysis' is about 'how people use discourse and how discourse uses people' (Potter et al. 1990, p.213). 'Discourse' is apparent in the actual discursive practices of people. It is manufactured out of pre-existing linguistic resources. The choice and selection of

¹ In his *The Archaeology of Knowledge*, Foucault (1972) pointed out that discourse not only restricts, limits and arranges what can and cannot be said about the phenomena within its domain, it also empowers (and disempowers) certain agents to speak on this or that question of fact. In many respects one might say

particular possibilities inherent in those resources is said to be dependent on psychological factors, seen as the orientation and interest of the speakers, who deal with the world around them in terms of discursive constructions or versions. These discursive versions can be abstracted from talk. People create them, use them, and become dependent on them. That is how discourse (now imagined to be prior to people's use of it) is said to 'use people'. 'Discourse' here is understood neither to be simply the ideology inherent in the sample of language studied, as suggested by Fowler; nor is 'discourse' seen to constitute a particular area of knowledge and social practice, like 'scientific discourse', 'medical discourse', and also maybe 'media discourse', as in Foucault. For example, Gilbert and Mulkay (1984) in their study of scientists' linguistic repertoires came to understand that 'scientific discourse' is not one discourse but two distinct discourses: one is based on 'an empiricist repertoire embodying many of the ideals of story-book science along with 19th century justificationist philosophy', the other is based on 'a contingent repertoire which is a fragmentary archipelago of notions about psychology, sociology, social interests and institutional functioning' (Potter et al. 1990, p.211). Here, two discourses, not one, are seen to sustain modern science.

Potter and Wetherell are social psychologists, and their version of discourse can be understood if one considers the academic tradition they are working in - and what they are 'arguing against' (see Billig, below). This tradition includes attitudinal studies which imagined attitudes to reside within individuals, to be uncovered by methods concentrating on the emotive and cognitive structures of these individuals. Potter and Wetherell developed their version of discourse analysis against the view that attitudes were something to be found within the individual. They say:

'We do not intend to use the discourse as a pathway to entities or phenomena lying 'beyond' the text. Discourse analysis does not take for granted that accounts reflect underlying attitudes or dispositions and therefore we do not expect that an individual's discourse will be consistent and coherent. Rather, the focus is on the

that discourse empowers certain agents to create representations, and thereby to authoritatively pronounce on the shape and form of the world' (Prior 1997, p.70/71).

discourse *itself*: how it is organised and what it is doing' (Potter and Wetherell 1987, p.49).

By directing their attention away from the individual and towards the study of discourse, Potter and Wetherell effectively bracket off any consideration of thinking (where the individual and discourse would have to be considered together).

Thinking, and thus the relationship between abstract discourse and real people, is something that Michael Billig has written about. In his book 'Arguing and thinking' (1989), Billig lays the foundations for rhetorical analysis, which bridges the gap between individuals and discourse, exposed by Potter and Wetherell and others. He writes about both the forms and the content of thinking. The most basic forms are the processes of categorisation and particularisation. Billig holds that

'Categorisation does not provide the basis of thinking in a simple sense. The automatic application of categories is the negation of thinking, in that it is essentially a thoughtless process. Thinking starts when we argue or deliberate about which categorisation to particularise, or how to categorise a particularisation' (Billig 1989, p.140).

We are thinking by putting things together into one category, or separating one particular thing out of a general category for special treatment – as well as arguing with others over the characteristics and contents of those categories. Rhetorical or argumentative thought is different from logical thinking, for 'within a rhetorical context, both a statement and its negation can be reasonable' (Billig 1989, p.164).

Rhetorical analysis always takes into account the rhetorical context. Attitudes, for example, are not seen to reside within the emotional or cognitive depths of the individual (here Billig is agreeing with Potter and Wetherell), but 'an attitude refers to a stance on a matter of public debate and disagreement' (Billig 1989, p.177). If there is no debate, no disagreement, nothing to 'argue against', then there are no attitudes – only generally held beliefs (as Billig says, 'the controversial aspect of attitudes implies that not all beliefs are attitudes' (ibid.)). Beliefs that are taken for granted do not require any arguments to

justify them or to rebut criticism of them, and individuals suddenly brought into a situation where they do have to defend their beliefs could be quite hard pressed to do so. This is not to say that they could not do so, however, as we are well equipped through the forms of our thinking (the strategies of categorisation and particularisation) to invent a novel argument.

But neither does rhetorical analysis stop at the discussions of (controversial) attitudes and uncontroversial beliefs. Billig goes on to discuss the dilemmatic aspect of common-sense. He says:

‘The contrary structures of our minds are not confined to the possession of those contrary forms which are used for shaping arguments, and which enable us to unpick categories by particularisation and to bundle particulars into categories. In addition, the contents of common-sense thinking may also be marked by contrary aspects’ (Billig 1989, p.192).

Common-sense is thought of as shared by a group of people. Billig uses it in the anthropological sense as referring to ‘particular versions of common-sense to particular communities or audiences’ (Billig 1989, p.201)², rather than ‘common opinions [...] which were held by all thinking, or reasonable people’ (ibid.). This first of all allows for arguments to arise between communities, but Billig goes further in saying that ‘the same common-sense will be the location of arguments which contradict each other’ (Billig 1989, p.203) – that is, within the same community (or even within the same person). Common-sense must be conceptualised as being made up of contrary aspects, ‘common-places’ as Billig calls them, that will be tugging into opposite directions. Billig argues that

‘It is because of this proximity between the undefined borders of opposites, that common-sense can provide us with the dilemmas to think and argue about; and, only if there are such dilemmas and deliberation, rather than the smooth and unthinking

² Billig also says ‘[...] if we say that all communities have their own common-sense, we are not implying that they are equally sensible’ (Billig 1989, p.201).

categorisation of all worldly particulars, can our discourse bear a moral quality’
(Billig 1989, p.208).

Billig’s version of discourse analysis as rhetorical analysis has direct relevance for this study. Euthanasia is generally represented as a controversial topic, one that people can have attitudes about (see opinion polls) and one that regularly invokes notions of common-sense. Although I am looking at newspaper texts, it is still crucial to hold on to the link between discourse and thinking individuals – for thinking has gone into the creation of the newspaper articles, and thinking is what makes the debate as a whole. Arguments about categories are the prominent feature of expert discourses on euthanasia, and attention to the strategies of categorisation and particularisation only makes the discursive structure in the data visible.

In my study of media representations of euthanasia, I inevitably use the term ‘discourse’ in different ways. I talk about ‘expert discourse’ on euthanasia and ‘media discourse’ on euthanasia as separate, while seeing both as part of a ‘public discourse’ on euthanasia, which itself is constituted of other ‘discourses’, for example around notions of agency or responsibility. Discourses, the way I understand them, are patterns in the structure of thinking and arguing about particular issues that can be discovered and described.

Narrative analysis

Narrative analysis can be seen as a type of discourse analysis, especially when the definition of the term ‘discourse’ is left quite open. Narrative analysis looks for structures across several texts: it looks at stories, how they develop, how one thing is said to lead to another. Vladimir Propp, who first applied narrative analysis to fairy tales, concluded that they all represented different versions of the same plot: the diverse characters and events were representative of the same functions, following the same basic story line (see Silverman 1993; Alasuutari 1995). Propp’s intent was to show that ‘the individual tales studied could be seen as variants of a single ‘macrotale’’ (Alasuutari 1995). This, however, need not always be the intention of narrative analysis. As Alasuutari points out,

stories may be structurally much more complex than fairytales, and depending on what elements the researcher singles out to classify stories, one might look like another, or nothing like the other, in the corpus of analysis. He holds that:

‘It cannot be argued, then, that the decisions made in the classification of stories are the only possible ones. Classification is not the main issue at all; it is a tool that often comes in handy during research. To study the structural features of stories by creating plot summaries and by summarising those summaries is helpful in the comparison of texts which may often be of extensive length. It is a means to discover both uniting and separating features. [...] In this way narrative analysis is helpful in locating the differences and similarities between different stories’ (Alasuutari 1995, p.74/75).

Alasuutari then goes on to say that narrative typology is not a research result itself. The way I understand this, and have applied it in this thesis, is that narrative analysis can be a means of ordering a large number of texts. Abstracting any story line and looking at the structural elements in the individual stories, one can quickly see which elements are present and which are not, and how they are presented – in a similar or in very different ways.

Narrative analysis is especially helpful when applied to newspaper articles. As Bell says: ‘Journalists are professional story-tellers of our age’ (Bell 1991, p.147). A lot has been written about the kind of stories that journalists and editors favour; as Golding and Elliott say: good news stories

‘exhibit a narrative structure akin to the root elements in human drama. [...] Dramatic structure is often achieved by the presentation of conflict, most commonly by the matching of opposed viewpoints drawn from spokesmen of ‘both sides of the question’. The audience is here felt to be served by being given the full picture as well as an interesting confrontation’ (Golding/Elliott 1996, p.406).

From a critical viewpoint, this reads: ‘the problem here is that journalists like to quote people with extreme positions, so that they come off in the middle as reasonable people. This allows any extremist to skew the debate’ (Pence 1998, p.1223). We can, then, expect newspaper stories to incorporate drama and embrace conflict – the question is, however, whether that should be our explicit object of analysis. My view is that we can draw on the findings of previous studies of the media. The fact is that we know quite well how the media in general presents news stories. It has been demonstrated that today, the traditional division into ‘hard’ news (serious, fact-based coverage) and ‘soft’ news (light, human interest oriented coverage) has broken down in wide sections of the media (see Henderson/Kitzinger 1999, p.66/67), and that we can expect to find elements of both in most news stories. What I am arguing here is that a study of media stories does not have to replicate studies that show that news stories involve drama, and a mixture of serious coverage and human interest angles, but it can use those findings as background information about news stories in general and go on to analyse the particular stories for their own particular aspects.

Both narrative analysis and discourse analysis, particularly in the form of Billig’s rhetorical analysis, allowed me to carry out a study of media representations of euthanasia, conceptualised as a study of cultural representations (elaborated in the previous chapter). Texts in general, and newspaper articles in particular, work on several levels, and consequently their analysis can take different forms. I have chosen narrative analysis because it directs attention to the organisation of newspaper articles on euthanasia as stories, and discourse analysis (or rhetorical analysis) because it enables a concentration on those elements of the stories that are not just about the narrative dimension, but relate to the structures of thinking and writing about the substantive topic, euthanasia. The actual analysis consisted of reading and re-reading, searching out particular words and phrases, counting words, juxtaposing paragraphs, looking for repetitions and contradictions, reflecting on what was being said and not being said, and so on. The structure of the thesis as it eventually evolved will be described in further detail in the section previewing the subsequent chapters below. But first, an introduction to previous studies of media representations of euthanasia.

Previous studies of media representations of euthanasia

As has been said in the previous chapter, there have been virtually no studies of how euthanasia is portrayed in the media. A search in the International Bibliography of the Social Sciences (IBIDS) yielded only one result for the combined keywords 'euthanasia & media' for the whole period between 1951 and 2002. The article 'Paging Dr Death: the political theatre of assisted suicide in Michigan' by Fino et al (1997) only peripherally touched upon the media. The article investigated the political drama unfolding around the activities of Dr Kevorkian in the USA (also see Chapter (5) on Dr Kevorkian). The media was mentioned in relation to those activities in terms of (a) the inherent newsworthiness of Kevorkian's activities, and (b) the conscious use which Kevorkian and his attorney, Flieger, made of the media in attempting to win over the public to their cause. In no direct sense did this article investigate media representations of euthanasia.

That IBIDS is not exhaustive can be demonstrated by the existence of another article, found quite by chance, that falls into the category 'euthanasia and the media'. 'Baby Jane Doe in the Media' by Klaidman and Beauchamp (1986) deals with the media coverage of the case of an American baby born with spina bifida and microcephaly. Surgery was required to keep the child alive, knowing that she would always be significantly handicapped even if the surgery were successful. A controversy developed over whether she should be kept alive at all (Klaidman/Beauchamp 1986, p.271). Klaidman and Beauchamp's article is a review of national television, magazine and newspaper coverage of the case. The controversy can be seen to fall into the category of euthanasia, although this word is not mentioned in the article itself and there is no suggestion that it played a role in the media coverage of the case. The review concentrates on evaluating media coverage of the case in terms of its accuracy, coming to the damning conclusion that 'most of it lacked perspective and context; stories were generally incomplete and often imprecise; reporting was sometimes inaccurate; and overall, inadequate attention was paid to the medical, legal, philosophical, and social implications of the case' (ibid.). One main finding was that:

‘[...] the moral issues illustrated or sparked by the case were cast in highly simplistic terms, as if the contest was simply between absolutist right-to-live advocates and those who contend that parents have an absolute right to decide whether a defective newborn should live or die. The coverage failed to convey that perhaps the majority of philosophers and physicians who have reflected seriously on this issue are in the vast middle ground, according – among other things – to individual views about the status of rights, fair treatment for the handicapped, and what constitutes an acceptable quality of life. Very little of the complexity of the debate and the breadth and depth of the moral divisions within the philosophical, medical, and legal communities were adequately covered by the news organisations we reviewed’ (Klaidman/Beauchamp 1986, p.281).

We can see that a major assumption of this review is that news reporting should adequately reflect ‘reality’. A lot of media analysis of health coverage in general used to assume the same thing, and still does (see Seale, forthcoming). While there is a continuing concern with ‘accuracy’ in media studies, it can be argued that the ‘reality’ that media coverage is being compared with is always a particular reality.

Straightforward ‘realist’ studies thus become problematic if one starts asking the question: whose reality? In the above article on the coverage of the case of ‘Baby Jane Doe’, ‘reality’ was the reality of ‘experts’ - philosophers and physicians who ‘have seriously reflected on this issue’. The position of Klaidman and Beauchamp is that the media should share in this reality, instead of creating its own ‘wrong’ (or preferred) account.

In studies of science coverage, however, it has become clear that the media was not adequately or inadequately reflecting ‘scientific reality’, but the reality as perceived by scientists³. If one starts from the assumption that reality is socially constructed, just as media messages are constructed, then any comparison between media coverage and the

³ This is supported by Nelkin’s research, which found that ‘the difficulty of evaluating a complex and uncertain subject converges with the day-to-day constraints of the journalistic profession to reinforce the tendency to rely uncritically on scientific expertise [...]. Many journalists have adopted the mindset of ‘frame’ of scientists, interpreting science in terms defined by their sources, even when those sources clearly display a special bias’ (Nelkin 1995, p.164). However, Nelkin also makes the point that this pattern was beginning to change in the 1990s, resulting in somewhat more critical and sceptical science reporting today.

‘real’ event has itself to be seen as constructed – and often constructed with particular interests in mind. There are two possible responses to the situation understood as such: firstly there is the conclusion drawn by ‘extreme constructionism’, which holds that everything is constructed, thereby everything (any sense of reality and different constructions of reality) gets conflated, and comparison becomes impossible. My own standpoint, and the one adopted by the great majority of researchers who carry out studies related to health issues in the media, is one which I will call ‘constructive constructionism’. This refers to an approach which is sensitive to constructionism, but does not discard realism. I want to argue that, although this is taking on an often uncomfortable position between what some people might take to be incompatible philosophical stances, this is the only position that makes any sense to hold⁴. To discard any sense of realism (in the sense of another reality or other realities outside the media) would be to discard any possibility of making comparisons, at least comparisons that have any relevance to a reality outside the texts – of course this argument only makes sense as long as one holds on to a notion of the existence of such a reality. It has to be remembered that what people believe to be real is real in its consequences (see previous chapter), and for that reason some sense of ‘reality’ needs to be considered. The particular comparisons made may be contested, but they serve as valuable reference points in grappling with diverse issues or problems. The discrepancy between the things that are being compared is then not the actual finding, it rather constitutes the starting point for an investigation into why there is this discrepancy, what it could mean – rather than, as in the review article of the ‘Baby Jane Doe’ case above, assuming that we already know what it means: that the media coverage is misleading and needs to be changed in accordance with reality outside the media. One thing it could mean is that the reality portrayed in the media might actually come close to the reality of some people outside the media, and if that is indeed the case, it would raise issues that a ‘realist’ study of the media could never deal with. In conclusion it can be said, then, that ‘reality’ for us is only ever a reality represented to us and by us (or somebody) in a particular way, which does not mean that a ‘reality’ beyond the one represented to us does not exist. It

⁴ See my MA thesis (University of Kent, 1999): ‘The shifting boundaries of nature and culture: implications for contemporary social thought’.

follows that the more interesting studies of media representations compare them to other representations of the same issue (rather than assuming that we know what ‘reality’ is, and comparing media representations against those other representations). Accordingly, this study of media representations of euthanasia does not compare them to the ‘reality’ of euthanasia; rather it is interested in divergences and discrepancies with ‘reality’ represented in a particular way, more specifically, the representations of ‘experts’.

Methods

This section discusses in greater detail the sample and the methods of analysis employed in carrying out this study.

Choosing the data: the sample

The aim of the study was to find out how the media represents euthanasia. It was not designed as a comparative study or as part of a study of the media in terms of production, representation and reception. It aims to look at media representations of euthanasia, to explore discourses in the media on euthanasia, and discourses that the media draws upon in its presentation of euthanasia, using textual analysis including methods of content, discourse and narrative analysis. In the pilot phase of the study, different possible data sets were compiled: video materials of documentaries and film shown on British and German television; medical and nursing journals; texts on euthanasia; an archive of articles on euthanasia for the last five years from the Times, the Guardian and the Independent, and so on. All of those were eventually discarded to favour a data set consisting of articles from British newspapers, both national and regional, spanning the course of one year (from November 1998 to October 1999). This data set was derived from LexisNexis (see below), and it was chosen because it would give access to a range of representations on particular events presented in terms of euthanasia, within a relatively short time span. It was anticipated that this data would generate evidence of the range of media representations of euthanasia for a particular point in time.

What is LexisNexis?

The data used in this thesis was acquired through the data service LexisNexis. LexisNexis was started in 1973, it prides itself in virtually creating the online information market. Today it is the world's leading source of news, legal, business information and market intelligence. LexisNexis has access to over 3.7 billion documents from 33,000 sources of reference (see <http://www.lexis-nexis.co.uk>) which can be accessed through the web.

LexisNexis offers several products. Universities in the UK which subscribe to LexisNexis (among them Oxford, the Open University, Leicester, Exeter, Bath, Sterling – but not the University of London) generally subscribe to a service called 'LexisNexis Executive' which gives access to news coverage from approximately 12,000 international, national and local publications. The data used in this thesis was derived from a trial version (available for one week). All the articles from British newspapers bearing the keyword 'euthanasia' in headline or text were selected (see also page 118)⁵. The table below shows the range of British newspapers and the number of articles (news reports, feature articles, editorial and commentaries) acquired through this procedure. The number in brackets is the number of articles that dealt with case stories which were subject to closer analysis in this thesis.

Numbers of British Newspaper Articles derived from LexisNexis for the 12-month period from November 1998 – October 1999: number of all articles with the keyword 'euthanasia' present in the headline or body of text (number of articles specifically dealing with cases):

⁵ This selection was compared to articles selected on the basis of the keywords 'assisted suicide': it was found that the great majority of the articles with the keyword 'assisted suicide' also held the keyword 'euthanasia', whereas the collection of articles with the keyword 'euthanasia' alone was a lot larger. In consequence, I decided to use the articles bearing the keyword 'euthanasia' as my main data set. This was after English-language newspaper coverage from around the world (US-American, Australian, Singaporean and so on) was screened out – incidentally, this selection process already led to the first finding on the British newspaper coverage of the issue of euthanasia, when compared with the American coverage: whereas America concentrates on a discussion of 'assisted suicide', very rarely using the term 'euthanasia', in Britain the term 'euthanasia' is the preferred one. It has to be noted, though, that the term and concept of 'assisted suicide' seems to be becoming increasingly popular in Britain as well, at least since the BMA called a conference in 1998, that was to discuss the issues around euthanasia, a conference on 'physician assisted suicide'.

London:

The Times	44 (21)
Sunday Times	5 (2)
Financial Times	12 (5)
The Independent	40 (11)
The Guardian	19 (13)
The Observer	4 (2)
The Daily Telegraph	7 (1)
Sunday Telegraph	2 (1)
The Evening Standard	10 (8)
Daily Mail	20 (13)
Mail on Sunday	8 (1)
The Mirror	18 (13)

Rest of England:

Western Daily Press (Bristol)	11 (4)
Bristol Evening Post	7 (3)
Bath Chronicle	3 (1)
Western Morning News (Plymouth)	5 (5)
Evening Herald (Plymouth)	3 (1)
Herald Express (Torquay)	3 (3)
Birmingham Post	20 (13)
Birmingham Evening Mail	5 (1)
Coventry Evening Telegraph	3 (0)
Leicester Mercury	1 (0)
Manchester Guardian Weekly	2 (0)
Nottingham Evening Post	1 (0)
The Journal (Newcastle)	20 (9)
Evening Chronicle (Newcastle)	5 (4)
The Northern Echo (Darlington)	3 (2)

Scotland:

The Scotsman (Edinburgh)	7 (4)
Scotland on Sunday (Edinburgh)	2 (0)
Evening News (Edinburgh)	2 (0)
The Herald (Glasgow)	16 (6)
The Sunday Herald (Glasgow)	4 (2)
Daily Record (Glasgow)	14 (4)

Northern Ireland:

Belfast Telegraph	2 (0)
Belfast News Letter	4 (1)

All Newspaper Articles 360 (133)

LexisNexis aims to be exhaustive in so far as it gives access to the complete range of all newspapers available. This proposition was tested by comparing the list of British newspaper sources of LexisNexis (which can be found in the Appendix) to a list of British national newspapers, available from the Audit Bureau of Circulation (ABC) [<http://www.abc.org.uk>], as well as the Top UK Regional Mornings Ranked by Circulation, the Top UK Regional Evenings Ranked by Circulation, and the Top UK Regional Sundays Ranked by Circulation, compiled by The Newspaper Society [<http://www.newspapersoc.org.uk>].

It was found that out of a total of 29 national newspapers, 3 were not available in LexisNexis:

1. The Star – Republic of Ireland (not a British newspaper)

2. Sunday People

3. Sunday Sport

Of 18 'Top UK Regional Mornings Ranked by Circulation', 6 were not available on LexisNexis:

1. Dundee Courier & Advertiser

2. Norwich – Eastern Daily Press

3. Newcastle-upon-Tyne Journal

4. Ipswich – East Anglia Daily Times

5. Ulster – News Letter

6. Paisley Daily Express

Of 20 'Top Regional Evenings Ranked by Circulation', 4 were not available on LexisNexis:

1. West Midlands Express & Star

2. Shropshire Star

3. Sheffield Star

4. Portsmouth – The News & Sports Mail

Of 10 'Top Regional Sundays Ranked by Circulation', 3 were not available on LexisNexis:

1. Sunday Post – Scotland

2. Newcastle-upon-Tyne – Sunday Sun

3. Sunday World – Northern Ireland Edition

On the other hand, 26 out of the 29 British national newspapers were available in LexisNexis, as well as 35 out of 48 of the Top Ranking (by Circulation) British regional newspapers – which is the large majority. Also, LexisNexis gives access to more regional

newspapers than the 'Top Ranking' ones, as the source list below shows. The data used in this thesis includes 5 regional newspapers that do not appear on the 'Top Ranking' lists:

1. Bath Chronicle
2. Evening Herald, Plymouth
3. Herald Express, Torquay
4. Manchester Guardian Weekly
5. Belfast News Letter

It can be concluded that although LexisNexis does not hold all British newspapers, it gives access to such a wide coverage of national and regional newspapers, including the most well-known and influential titles, and the majority of those with the highest circulation, that a sample of British newspapers articles derived from LexisNexis for a 12-month period can be regarded to be adequately representational of British newspaper coverage for that period.

Carrying out the analysis: analytical tools

As has been pointed out earlier, the actual analysis of the data did not adhere to one specific mode of discourse analysis. Rather, the approach taken here is eclectic, using the insights of different methods developed for analysing texts and making use of them in thinking about the data. Apart from straightforward content analysis, the analysis of texts is invariably an exercise in qualitative research. It can be argued that in qualitative research, the role of the researcher comes to the fore in a more obvious way than is the case in quantitative research, where construction of the data and subsequent analysis depends upon the articulation of standardised research procedures and techniques. The first premise of qualitative research is that the researcher is part of the same social world that she is trying to describe. An honest engagement with any element of this social world must always involve the constant questioning of one's own assumptions and beliefs.

In his article ‘Methodology and scholarship in understanding ideological explanation’ (1988), Michael Billig discusses the difference between what he calls ‘traditional scholarship’ and ‘methodology’. Methodology, he says, ‘attempts to standardise the practice of the social sciences and eliminate quirks. [...] the methodological procedures [...] can be followed by anyone with sufficient training’ (Billig 1988, p.200). In traditional scholarship, on the other hand,

‘it was taken for granted by the traditional scholar that one should read as widely as possible, and in as many languages as possible. Through wide reading, breadth and depth of knowledge would be gained, as well as the ability to make connections between seemingly disparate phenomena. The learned scholar would be able to interpret individual texts with an acuity not available to those of restricted reading’ (Billig 1988, p.200).

For Billig, the wide reading, thinking and making connections, the historical knowledge and sensitivity, of traditional scholarship are the prerequisite to be able to do good qualitative research, which in his case means good discourse or rhetorical analysis. Without it, social science methodology too easily falls back onto common-sense terms as the jumping-off points for the real analysis, forgetting to investigate those common-sense notions in the first place⁶.

I agree entirely with Billig, and accordingly from the beginning of the research process, I have read and watched everything that I could find on the topic of euthanasia: from academic articles of all different disciplines to novels dealing with the topic (for example Aidan Chambers’ ‘Postcards from No Man’s Land’ (1999) and Ann Widdecombe’s ‘The Clematis Tree’ (2000)); from an episode of Peak Practice on television to the responses to the program on an Internet chat site the following day; from the British Medical Journal to resources on the Internet provided by the British Medical Association and the Voluntary Euthanasia Campaign (among others); and from German and Spanish newspaper articles to German literature and fiction. A short commentary on

⁶ See also: Cicourel (1964)

an episode of the BBC1 series 'Murder in Mind' can be found in the postscript to Chapter (7).

This background reading, to acquaint myself with the range of representations currently available on the topic of euthanasia, forms an indispensable part of what Billig calls 'scholarship'. The methods employed in this thesis consequently have something in common with the tradition of literary analysis, as much as empirical sociological analysis. Here I have been influenced by what is called the 'linguistic turn' in sociology which has introduced methods of literary analysis as an acceptable part of the repertoire of sociological analysis.

Guiding questions

The texts to be analysed were approached with the following guiding questions in mind:

- What kind of stories does the press tell about euthanasia? In those stories, how does the press construct the concept of euthanasia? What is the concept of euthanasia taken to mean and what is it set in relation to?
- Is there a discernible media discourse on euthanasia? Does the press make evaluations and what are they?
- How is discussion of euthanasia contextualised? What are the recurring issues in press discussion of euthanasia?
- How does press discourse on euthanasia relate to 'expert' discourses?

These questions structured the actual analysis, which will be described below.

The analysis

The data set was available on disc and as paper print-outs. All that was available was pure text – additional features of the original newspaper version (the place arrangement of the article within the paper and on the page, photographs accompanying the article, and so on) were absent. The analysis consequently concentrated on the text. The text was

analysed with the help of the computer programme NVivo, which has been designed to aid in the analysis of qualitative data. More than just allowing for coding and retrieval, NVivo has facilities for coding, linking and searching in flexible ways, for example it is possible to search for a combination of words that appear in proximity, within a sentence or a paragraph. I mainly used the word/phrase finding facility and the facility to create documents juxtaposing sections of different articles that were identified to cover similar issues. The actual analysis consisted essentially of three operations:

1. *Basic counting*: for example, counting the number of times particular words appeared in the texts, such as the term 'euthanasia', and also the number of times it appeared qualified ('voluntary euthanasia', 'involuntary euthanasia', 'non-voluntary euthanasia') as opposed to unqualified (just 'euthanasia'); likewise with terms like 'assisted suicide', 'mercy', 'choice', 'kill', etc.;
2. *Looking for keywords and phrases as indicators of different discourses, and exploring those discourses*: for example, concentrating on the paragraphs in which words like 'choice', 'chosen', 'autonomous' appeared and working through representations of voluntariness; tracing the use of the terms 'mercy' and 'love' in the context of the stories and reflecting on the portrayal of relationships; looking at the way doctors and patients were portrayed (actors versus acted upon); looking for reference to countries ('British', 'English', 'Scottish', 'Dutch', 'Holland', 'Netherlands', etc.) in context; collating the terms and phrases used to describe the acts of 'killing' and 'letting die'; looking for descriptions and explanations of concepts like euthanasia ('Greek' definitions, 'Nazi' meanings, reference to 'history'); and so on;
3. *Looking for and comparing narrative structures*: in the texts, who are the actors, who are the other people that appear, how are they being portrayed, what event is being presented and how, and also: how are these portrayals similar and how do they differ between stories, what is recurrently being referred to and what is missing.

It must be stressed that the analysis was data-led, it tried to explore what came up from the data, rather than imposing categories from outside onto the text. In consequence, the empirical chapters in this thesis (Chapters (5) to (8)) are the result of the application of those operations to these particular texts, which occurred in several phases:

- a. After a first phase of carrying out the above mentioned three operations on all texts, it was found that the articles discussing events – telling stories – where euthanasia played a role were more detailed on the issue of euthanasia itself and the sentiments around it than those articles where the word ‘euthanasia’ appeared only peripherally in a different context (presenting a new book, recording a visit by the Pope, a short notice about the proposal of a new policy). It was decided that the articles telling stories were thus most fruitful for analysis – thus after a first phase of applying the above three operations to all texts, the second phase concentrated on the articles telling stories. Firstly, narrative analysis was applied to those articles. This involved, among other things, the development of a ‘truth table’ – a technique based on logic (as described in Becker (1998)) which makes possible the description of a complete universe of interdependent concepts that can then be used to ‘squeeze more out of our data, and find more things to study’ (Becker 1998, p.166).
- b. Out of the second phase, the key concepts that structure the portrayal of euthanasia in the media slowly emerged: a description of ‘voluntary euthanasia’ and the ‘terminal illness’ discourses were developed by moving between the data and social theory.
- c. A third phase dealt with other features of the articles that were too important to dismiss, thus the reference to other countries and how this anchors the discussion of euthanasia in the media was pursued.

According to Tonkiss, ‘discourse analysis is a messy method’ which has a ‘resistance to any formulaic rules of method’ (Tonkiss 1998, p.250/251). She also states that there are certain useful techniques in relation to sorting, coding and analysing data; such as, tracing key words and themes in the texts, looking for variation in and between texts, reading

from emphasis and detail, as well as attending to silences (Tonkiss 1998). All of those techniques were employed when I analysed my data, starting with the themes of the story, the key words ‘choice’ and ‘terminal illness’, and reference to other countries. There was a continuous movement between theory and the texts which is typical of discourse analysis. The empirical chapters are the result of this kind of engagement with my data.

An introduction to the chapters that follow

This section introduces the subsequent chapters of the thesis. Chapters (4) and (5) establish the context of the analysis with overviews of how the concept of ‘euthanasia’ is used in both in expert and press discourse, while chapters (6), (7) and (8) analyse press discourse more closely.

Chapter (4) looks at ‘expert discourse’ on euthanasia. In the present chapter I have dealt with the concept of discourse, explaining that I use it to mean a set way of conceptualising, thinking or talking about a particular issue, process or state. The term ‘discourse’ therefore can relate to set ways of thinking or talking connected with a particular social group or profession (‘expert discourse’, ‘medical discourse’), or to ways of thinking or talking shared more widely within a society or era (for example the discourse of individualism that structures social life on many levels). ‘Expert discourse’ really is an amalgam of diverse discourses connected to various professions and academic disciplines. I have grouped them together for the purpose of this thesis, because they make up the visible and authoritative part of public discourse on euthanasia. It is visible because it is publicly available in books and articles; and it is influential not only because of the power our society attaches to the opinions of experts, but also and even more so because many of those experts are in positions to influence praxis with their opinions. Also, their opinions are often seen as more than mere opinions, they are expected to be closer to the truth about a particular subject – even though a closer proximity or deeper insight into a problem does not mean that diverse opinions melt into one single truth. This can be seen in expert discourse on euthanasia, where doctors and philosophers have different views of what the concept of euthanasia refers to, its status and legitimacy, but even among doctors and among philosophers there is no agreement, because some start

from different premises than others. The purpose of this chapter on ‘expert discourse’ is then to give an overview of the current state of expert debate on the topic.

The term ‘expert discourse’ is consciously chosen in contradistinction to the term ‘media discourse’ or ‘press discourse’. This, again, relates to something I mentioned earlier in relation to the value of comparison and the notion of constructive constructionism. We have seen that it is problematic to compare media discourse to ‘reality’. Reality is always a particular reality. The comparison then would be between a constructed media discourse and a ‘constructed reality’ (for example, constructed by expert discourse). The topic is euthanasia. The practice of euthanasia is hidden from public view, and it can only be accessed through the public discourse there is on it – a large part of which happens to be what I will call ‘expert discourse’. It makes sense therefore to compare how the media present euthanasia against how experts talk about euthanasia. The comparison is ‘constructed’, because there really are no wholly separate realms of ‘experts’ and of ‘media’. Experts make use of the media and are being quoted (and sometimes even constructed as ‘experts’ in the first place) by the media. The media rely heavily on expert understandings. However, that is only one dynamic that shapes media discourse. The diversity of opinion among experts also means that the media can choose whose opinion they want to endorse. The media clearly have other objectives than to represent expert discourse faithfully⁷. Thus, expert discourse plays a part in media discourse, but expert discourse and media discourse can analytically be conceptualised as independent elements of a more general public discourse on a particular topic, in this case, euthanasia⁸. I should stress again that I am well aware that the concept of ‘expert

⁷ A lot of research has been done into the media reporting of scientific issues, which has shown that ‘the evidence presented in the media [...] is often problematic. In the field of medical reporting, it frequently fails to accurately represent the original research designs, or findings or to clarify the limitations or qualifications of research. [...]’ (Clarke 1999, p.114). It is obvious that journalists and scientists inhabit what can be called different realms of discourse that follow different institutionalised rules and practices: ‘While scientists are socialised to qualify their findings, journalists may see qualifications as protective coloration. Furthermore, readability in the eyes of the journalist may be oversimplification to the scientist. Indeed, many accusations of inaccuracy are traceable to reporters’ efforts to present complex material in a readable and appealing style’ (Nelkin 1995, p.166). This may seem to clash with the point made on p.49 – of journalists adopting the frame of scientists. However, it is perfectly possible for a journalist to take his or her cues from the way scientists frame their topic, at the same time as simplifying the point.

⁸ Billig et al in the book ‘Ideological dilemmas’ (1988) make a distinction between ‘lived ideology’ and ‘intellectual ideology’. ‘Lived ideology’ seeks to describe the social patterning of everyday thinking, it includes what passes for common sense within a society. They say: ‘It may be said that ordinary people living in a particular society partake in the general cultural patterns of that society, and their thinking is

discourse' is a concept created for a particular purpose: that is, as a point of comparison, playing the part of a 'reality' outside media discourse, one which media discourse on euthanasia can be set in relation to. This represents an attempt at constructing a comparison that will yield understandings that are found in the difference between things that are related, as opposed to findings that apparently float in the void of extreme constructionism, unrelated to anything.

Apart from providing a comparative context for media discourse on euthanasia, chapter (4) also stands independently as a reflection on the current state of expert debate on euthanasia. It is an exercise in 'sorting things out', firstly, by showing differences in the way euthanasia is conceptualised by experts; the arguments over what the concept does and does not refer to, and how the practice is to be evaluated. Secondly, I have tried to show how the divergent concepts and what follows from them (treatment versus care, extraordinary versus ordinary treatment) can be brought into relation with each other to form a coherent framework, by showing the problems and contradictions with different conceptualisations. In my view, it is impossible simply to describe a state of debate. 'Sorting things out' is always done with some kind of ordering mechanism in mind, which might as well be made explicit.

The following chapter, chapter (5), explores press discourse on euthanasia in the form of the stories that are told in newspapers. The 328 articles that comprise my data, selected as described above, can be divided into 42 different story lines. 13 of those are what I call 'case stories', stories about individual cases that centre upon euthanasia (as opposed to reports about legal or policy developments in relation to euthanasia, etc.). It is these case stories that my analysis concentrates on, in this as well as the following chapters. We have seen, above, that stories are important in news reporting, and hence narrative analysis could yield important insights. The method of narrative analysis I applied did not look at the detailed narrative structure of individual articles in themselves, or compare how the same story is developed differently in diverse articles of different newspapers

shaped by these patterns' (Billig et al 1988, p.28). 'Intellectual ideology', on the other hand, refers to systems of political, religious or philosophical thinking and is the product of intellectual and professional thinkers. Using these concepts, expert discourse would clearly be an instance of 'intellectual ideology'. Media discourse would have to be conceptualised as somewhere between 'lived ideology' and 'intellectual ideology', for it formalises (in writing) particular ideas that have their origin both in expert discourse and

(for example, tabloid versus broadsheet). I had a particular interest in exploring how the concept of euthanasia was constructed in those articles, and I used narrative analysis as a tool to summarise the plots of the stories in terms of the dimensions that related to euthanasia – the portrayal of the action, the actors, and so on. In this I have followed Alasuutari who has already been quoted above:

‘To study the structural features of stories by creating plot summaries and by summarising those summaries is helpful in the comparison of texts which may often be of extensive length. It is a means to discover both uniting and separating features. [...] In this way narrative analysis is helpful in locating the differences and similarities between different stories’ (Alasuutari 1995, p.74/75).

For me, then, as for Alasuutari, narrative analysis does not lead to an end result in itself; rather, it leads to a better understanding of the research material one is dealing with. To summarise plots is to re-present what is there in a different format, more easily analysable. The analysis not only describes, but rather makes an argument. The articles themselves give the impression they are dealing with media representations of ‘real’ events outside the texts. These are not only represented in a particular (media) way, but also can be misrepresented. The articles purport to deal with real events that have really happened, although the way the media presents them also plays a part in how their reality is understood. The observation that all the stories in this data set are presenting conflict is important, because it alerts us to the silences in media accounts where there might be no (open) conflict.

In summary, it can be said that chapters (4) and (5) are offering overviews of the use of the concept of ‘euthanasia’ as it is debated in expert discourse and presented in press discourse. They address the questions of the meaning of euthanasia, how it is applied, and what it represents.

Chapter (6) looks more closely at the largest case in the data set, the Dr Moor case. The quasi-medical concept of the ‘double effect’ features prominently in the press

lay discourse. Media discourse thus may influence (and be influenced by) ‘lived ideology’, but it cannot be equated with it.

discourse in relation to this particular case. It straddles the boundary between killing and not killing, between intentional and unintentional killing. This is the critical and contested issue in this particular case.

Chapter (7) develops the main argument by presenting the discourses that structure the press coverage of euthanasia stories as a whole. Here, ‘discourses’ are understood to be set ways of thinking and talking about euthanasia that can be abstracted from the press coverage of the news stories presented in terms of euthanasia. Here, I argue that press representations of euthanasia are structured around a major discourse, which I call ‘terminal illness discourse’, and a minor discourse, the ‘voluntary euthanasia discourse’. The issues that those discourses address centre around the notions of agency and responsibility. I shall draw on current discussions of agency in social theory to make analytical sense of the discourses present in the press. The research reported in this chapter thus represents an exercise in discourse analysis. The aim is to begin to see structures, recurrences of particular elements, and significant absences. ‘Seeing’ these things only became possible after reading, re-reading, reflecting and then coming back to the data, until – slowly – a pattern emerged.

Chapter (8) is also the result of an intense engagement with the data – in its own terms rather than in terms derived from outside the texts (pace chapter (5)). It emerged that a major feature of press discussion on euthanasia is the construction of the issue (as a problem) in its temporal and especially spatial dimensions. As did the previous chapter, chapter (8) draws upon current social theory, this time theories of globalisation. The starting point of the chapter is the finding of an interesting discrepancy between the immense importance of the ‘national’ in reporting and discussing euthanasia in the press, and the emphasis upon the ‘global’ in social theory. Theorists of globalisation would, for example, hold that the media today represents a significant globalising influence (something which, as we will see, can be contested). What this chapter provides is a critical inquiry into both the construction of the ‘national’ in press discourse on euthanasia and the construction of the ‘global’ in globalisation theory, in order to reflect on how the issue of euthanasia is being represented in the press and beyond. This last chapter opens an issue that goes beyond the confines of this thesis: how the greater changes taking place in societies across the globe might reshape contemporary ideas

about euthanasia considerably in the near or not so near future. All that can be shown at this point is whatever the global changes that social theorists are dealing with, press discourse has not caught up with them. Press discourse, at least on euthanasia, is presenting the issue in terms that are domestic and familiar (the national context) – which has implications for cultural representations on euthanasia beyond the media, which can be expected to change just as slowly.

The concluding chapter (9) summarises the main points that have come out of this investigation, and concludes with final comments on shortcomings and suggestions for further research.

Conclusion

The present chapter has provided the methodological background to a study of euthanasia in the media which employs a version of qualitative research closer to literary analysis than to traditional sociological empiricism (meaning that the exploration of categories and themes in the texts represents the central aim of the thesis). Different methodologies for studying texts were presented in terms of their insights relevant to this study. A section on methods has discussed the sample and the analytical tools made use of in the research. This final part introduced the following chapters as they stand as a whole; the next chapter will continue with a discussion of ‘expert’ representations of euthanasia.

Chapter (4) – ‘Expert’ Representations of ‘Euthanasia’

Introduction

The term ‘representation’ refers to the ways that human beings have developed for telling others what they think they know (Becker 2000) – ‘representation’ as a concept thus combines the construction and the communication of knowledge. This is often done through language, but by no means exclusively or always. ‘Representation’ can for example be or include the visual, as is increasingly recognised by the practitioners of visual sociology. In this study, my interest is in the representation of ‘euthanasia’, that is I am concerned with the construction and communication of the ideas and practices that are talked about under the heading of ‘euthanasia’. I am concerned with language only, excluding the range of visual representations of ‘euthanasia’ that exist for example in documentary and other films, having chosen to look at newspaper articles. This choice was influenced by considerations of time and space limitations, rather than any inherent valuation of representation via language as opposed to pictures.

Selective literature review

There exists a relatively large amount of literature on euthanasia, partly because different disciplines are interested in the topic from their specific point of view; partly because it is an issue that people tend to feel quite passionate about - one way or the other. Also, euthanasia represents an issue that has so far defied a satisfactory resolution, and many people feel they have something to contribute.

What follows is a selective literature review, presenting books and articles that deal with euthanasia in different ways. In that sense, it tries to show the different types of literature that are available on the topic of euthanasia.

Euthanasia in different countries and cultures

First, there is the literature that deals with the particular situation in diverse countries. There is a large literature that deals specifically with euthanasia in the Netherlands, both by Dutch and foreign commentators. Some of them explicitly condemn the situation in that country, where the practice of euthanasia has progressively been decriminalised over the last couple of decades (Fenigsen, 1989; Zykić, 1995). In contrast to that, there have been a number of careful, large-scale studies into the practice of euthanasia in the Netherlands (van der Maas et al, 1991 and 1996; Pijnenborg et al, 1994), trying to assess the situation. Pool (2000) has carried out a participant observational study in a Dutch hospital, looking at euthanasia as a part of terminal care.

There is an equally large number of books and articles on the USA, which has addressed the few attempts at legalising physician-assisted suicide in different states in the 1990s. Some contributions consist of polemics for (Dority, 1996; Hallock, 1996) or against (Nuland, 1998; Smith, 1994) the legalisation of euthanasia, or physician-assisted suicide. The cost of dying, and specifically the costs of PAS are issues that are being discussed for the American context (Scitovsky, 1984; Fung, 1993; Felder, 1996). Battin (1992 and 1994) looks at the situation in other countries (Netherlands, Germany) to see whether their experience is helpful for the American case. Spragins (1999)¹ has written a metaphorical analysis of the American debate on physician-assisted suicide.

Australia's Northern Territory saw the legalisation of euthanasia for a short period of time in 1995: Ryan (1996) discusses the Northern Territory Rights of the Terminally Ill Act.

¹ Initially I thought Spragins' work would be directly relevant to this thesis, considering that she looked at metaphors in the American PAS debate, and I am also concerned with language of the euthanasia debate. However, her metaphorical analysis turned out to be restricted to the rhetorical aspects of the American PAS debate as represented in the published works of three American physicians: Jack Kevorkian, C. Everett Koop and Timothy Quill. She drew out the diverse metaphors that their respective arguments are based upon (for example, the physician as lesser deity, as judge, business man or warrior; medicine as primitive religious cult and doctors as mad scientists; treatment as war, as ritualistic torture; and so on) and subsequently proceeded to develop her own argument promoting the metaphor 'treatment as a crusade against disease' as the most beneficial tool to anchor the debate on PAS, as it did not antagonise physicians and patients, but worked to bring them together in a 'crusade' (not as impersonal and aggressive as 'war') against 'disease' (singled out as the enemy, rather than physicians and patients turning onto one another). A metaphorical analysis of the euthanasia debate in the press might well have been possible, but I decided against following that route as other issues appeared to emerge more readily from my data.

It is also possible to find literature on countries and cultures that are not obviously in the process of thinking about legalisation of euthanasia: Berger and Berger (ed) (1990) contains contributions on Indian, Japanese, African and Islamic views on euthanasia.

Not all books deal with the contemporary situation. There are also investigations into the history of euthanasia: Emanuel (1994) looks at the history of the euthanasia debates in the US and GB. There is particular interest in the history of euthanasia in Germany: Burleigh's book 'Death and Deliverance' (1994) gives an account of the euthanasia programmes of the Nazis. Other articles deal with the relevance of the Nazis' practice of euthanasia for contemporary euthanasia debates (Glock, 1994; Cavanaugh, 1997). Leichentritt et al (1999) have looked at Holocaust survivors' perspectives on the contemporary euthanasia debate (in Israel). Hörster (1998) has written about the place of euthanasia in the secular state for contemporary Germany.

Philosophical and ethical issues around euthanasia

Secondly, there is the literature that deals with the phenomenon of euthanasia relatively abstracted from particular situations. There are books that lay out the ethical and philosophical arguments around euthanasia (Campbell and Collinson (1992) generally on euthanasia, McLean and Britton (1997) on physician-assisted suicide – although both are written for the British context), as well as many articles on the ethics of euthanasia (for example Wilkinson, 1990; van der Wal, 1993; Winkler, 1995). Those articles introduce definitions, and often argue a case (Wilkinson against active, voluntary euthanasia; van der Wal against the unrequested termination of life, with the provision that in extreme cases it could be justified). Billing and Block's article 'Slow euthanasia' (1996) equally introduces a particular definition to make an argument (defining pain-relief that may have the side effect of hastening death as a form of euthanasia). Deigh (1998) writes about the differences between physician-assisted suicide and voluntary euthanasia.

Dunnett (1999) is a collection of expositions by various (British) personalities (for example Baroness Warnock, Cardinal Winning, Sir Ludovic Kennedy) on their views for or against euthanasia, aimed at the more general, less academic market.

Euthanasia is discussed in Spiers (1997), as one aspect of the more general problem of making moral choices in healthcare.

Euthanasia is also an issue in the hospice literature, which expounds a philosophy of how to treat dying patients – involving the rejection of euthanasia (Saunders, 1979, 1980, and 1992; Saunders and Baines, 1993; Foley, 1997). Logue (1994 and 1995) argues the case for euthanasia in direct reaction to this hospice philosophy. Other commentators on contemporary palliative care include euthanasia in their discussion, arguing that it is an issue that must be addressed (Clark and Seymour, 1999; Clark et al, 1997).

The social dimension of euthanasia

Thirdly, there are investigations into and commentaries on the meaning of euthanasia for different social groups. There are articles about the incidence of euthanasia among homosexual men with AIDS (Bindels et al, 1996, in the Netherlands), the experiences of and implications for the elderly (Lester, 1994; Kelner, 1995), and the implications for women (Logue, 1991; Wolf, 1996 – see also Parks, 2000, on ‘why gender matters in the euthanasia debate’). Emanuel et al (1996) look at the experiences and attitudes of oncology patients, oncologists, and the public. Surveys of attitudes exist for anything from the Dutch public (see van der Maas et al, 1995, on changes in Dutch opinions on active euthanasia over time), to Canadian MDs (Sawyer, 1994), Australian doctors (Waddell et al, 1996), Norwegian physicians (Førde et al, 1997) and British NHS doctors (Ward and Tate, 1994).

Seale (1997) offers a review of studies into the social and ethical aspects of euthanasia, providing yet more references than are mentioned here. They include references to studies that ask questions like why people want to die earlier (Seale and Addington-Hall, 1994), the paradoxical trends in public opinion in relation to voluntary euthanasia and issues of awareness of dying (Williams, 1989), and the sociological perspectives on euthanasia (Howarth and Jeffreys, 1996).

Personal and fictional accounts

Lastly, there is what I will call the more personal and fictional literature. The personal literature involves accounts of real cases of euthanasia by people who were involved with them (Humphry, 1987²; see also Staberoh, 1998, for an account of the last phase of the life of a disabled child, where euthanasia is explicitly rejected). Also, there are doctors reflecting on euthanasia, for example Keizer (1997), a Dutch nursing home doctor writing about his experiences; or Peck (1997), who from a very personal perspective discusses euthanasia, and develops an understanding of it which is in line with his other more esoteric books (for example 'The road less travelled', 1990) (see also Jung, 1995). 'Postcards from No Man's Land' by Chambers (1999) is a novel set in the Netherlands which involves an elderly woman choosing euthanasia; while 'The Clematis Tree' by Widdecombe (2000) is the fictional account of a family's life with a disabled son at the time that a euthanasia bill is brought before the British parliament.

This hugely diverse literature is not easily summarised. What can be said about all the books and articles on euthanasia mentioned here is that they have to start from a definition of what euthanasia is. Some make this the explicit topic of their discussion, others strategically employ (consciously or not) one particular definition of euthanasia while making an argument. There are two books which I have not mentioned in any of the categories above because they cut across at least the first three categories. They both are edited collections that bring together contributions by different authors variously dealing with the ethical, medical and legal aspects of euthanasia (Keown (ed), 1998, mainly for Britain; Emanuel (ed), 1998, mainly for the USA).

Situating the Keown book

To be able to say anything meaningful about the contemporary euthanasia debates, one both has to focus, and look at a variety of points of view and arguments. In an attempt to do both, I have decided to take a closer look at one single book (my focus: 'Euthanasia

² As one of the founders of the Hemlock Society in the USA campaigning for voluntary euthanasia, Humphry has also written a 'how to' book on what he calls 'self-deliverance' (Humphry (1991)).

examined', 1998, by Keown (ed), choosing the British rather than the American collection), but which consists of eighteen contributions by experts in their diverse fields, coming to the topic of euthanasia from different perspectives – providing me with a variety of arguments. This book forms the basis for the discussion in this chapter.

John Keown is the editor of the collection 'Euthanasia examined – ethical, clinical and legal perspectives' (1998). He is presented as a lecturer in the law and ethics of medicine in the Faculty of Law of the University of Cambridge, as well as a Fellow and Tutor at Queens' College, Cambridge. In the book, he has written the Introduction and later on (not until Chapter 16 out of 18) a chapter entitled: 'Euthanasia in the Netherlands: sliding down the slippery slope?'. His Introduction is a brief and informative 5 pages long, while the chapter criticises the Dutch Remmelink Survey and Report by reinterpreting their data through his own definition of euthanasia, rather than in terms of theirs. It appears that his personal stance is to be critical of euthanasia, however he makes it clear in the Introduction that the aim of the book is to 'bring together papers by some of the world's leading experts in ethics, medicine and law, to inform anyone interested in the debate. It is intended for the reader seeking rational debate rather than ranting polemic and is aimed at both experts and lay people. It should be readily intelligible to the general reader: no expertise in ethics, law or medicine is either assumed or required' (Keown 1998, p3). In fact, he sees rational debate by experts in direct contradistinction to the sensationalist media, writing: 'How regrettable, then, that the debate is often characterised not by cool reason but by hot air, often fanned by a sensationalistic mass media which seeks, typically by way of an exclusive and manipulative focus on the 'human interest' angle, to generate emotion and disagreement rather than reflection and consensus' (ibid.). We are told that 'the genesis of the idea for this book was a national conference on euthanasia held at the University of Leicester in October 1991. Five of the chapters are updated versions of papers delivered at the conference. The remaining papers have been specially commissioned for this volume' (ibid.). The book was first published in 1995, then updated and published again in 1998. It was written by professors of ethics and bioethics, theology and neurosurgery, as well as professors and practitioners of law, clinicians and one voluntary euthanasia activist (the only woman among this whole range of eminent men). It would be impossible to detect a general tendency in any way either in favour or

against euthanasia (although it is sometimes possible to derive from the contributors' texts where individual contributors stand). The book has been chosen for detailed analysis, because it is both representative of expert discourse on 'euthanasia' in general (spanning diverse disciplines and covering a range of subjects from advance directives to withdrawing treatment in vegetative patients), and unique in bringing together the arguments that were discussed in relation to 'euthanasia' at the time: 1998, which is very close to the time that the newspaper data (Nov. 1998 – Oct. 1999) stems from. The book can thus be understood to be an artefact which has been produced at a particular time for a particular purpose, and yet it is precisely those attributes which make it so interesting as a background reading to a study of media representations of euthanasia.

In this chapter, I intend to map out the different ways of defining euthanasia that characterise the contemporary euthanasia debates with the help of this book. As Howard Becker says: 'on the most superficial inspection, almost any factual question about society displays a strong moral dimension, which accounts for the ferocious battles that so often occur over what seem to be minor matters of technical interpretation' (Becker 2000). Euthanasia is a subject which is extremely morally laden, which becomes apparent on the first inspection of the articles. The articles are arguments about the morality and/or the management of euthanasia. Arguments about morality enhance their persuasive effort with reference to 'facts' (that experts in other disciplines, for example sociology, have established through empirical investigation), whereas arguments about the management of the practice are based in ideas about morality and invoke selected 'facts' to increase credibility. As there are no social scientists recognised as experts in their own right by this book that seeks to give an overview over the debate of this 'one of the most pressing and profound issues confronting the modern world' (Keown 1998, p.1), I will make reference at the end of this chapter to the work that has been done in establishing the 'facts' about the practice by empirical studies, for example by sociologists (here moral ideas are of course influential in both research design and evaluation/theorising). Clive Seale's article 'Social and ethical aspects of euthanasia: a review' (1997) provides an excellent summary of those studies.

What follows is an attempt at representing 'expert' representations of 'euthanasia'. I will discuss their representation of 'euthanasia' through the categories that they use in

determining what to include in or exclude from the concept. I am aware that my representation of others' representations is constrained by the same conditions as representation in general: it is always constructed and situated and coming from a particular point of view. My particular point of view is a secular one, I am lacking a strong opinion on the morality or practicality of allowing the practices that are variously described as euthanasia. Sociology produces 'situated knowledge' (Doyle McCarthy 1995). In this case, I am trying to make an argument about the multiplicity of arguments that experts make with respect to euthanasia. In that, I have to be selective and can only represent parts and never the whole of their arguments. As said before, expert discourse feeds into media discourse. An understanding of expert discourse will therefore be helpful as a preliminary to the study of media representations of euthanasia, keeping in mind the guiding question (see Chapter (3)) which asks how press discourse relates to expert discourses. As we will see, two representations derived from expert discourse (the representation of euthanasia as a medical issue, and the representation of euthanasia as being concerned with the concepts of mercy and autonomy) will actually be influential in developing the hypotheses which will provide me with points of entry in the newspaper data. The remaining part of this chapter will present 'expert' representations of 'euthanasia' through a reading of the Keown book.

Euthanasia as part of medical care

The introduction by John Keown to the book 'Euthanasia examined' begins with the following sentence:

'Euthanasia – the intentional killing of a patient, by act or omission, as part of his or her medical care – is, without doubt, one of the most pressing and profound issues confronting the modern world' (Keown 1998a, p.1).

The first thing to be noted about this abstract is that the practice of euthanasia is firmly set into and restricted to the medical context. This is a very important point. Euthanasia is something done to a *patient* as part of his or her *medical care*. Done by whom? Presumably by the doctor or some other health professional. This shows clearly the

medicalisation of euthanasia. The discussion of euthanasia performed by family or friends or people in other relationships to the person killed is thereby excluded. This sets the tone for the whole book – the contributions concentrate primarily on what exactly it is that doctors do, what they should do and what they should not do. Because euthanasia is perceived in the context of medical care and doctors, questions arise as to whether euthanasia can be conceived of as something like a form of treatment, or whether it is something else altogether. Controversies arise over boundaries and categories. What are the categories, what are the boundaries between them, what follows from establishing particular categories and boundaries?

Acts and omissions

What is it that doctors do? A second part of the above definition points to the central controversy running through the whole book: that is the question of euthanasia by act (which could be the injection with a poison) or omission (not doing something, withholding or withdrawing vital life-saving treatment). Keown puts forward an inclusive definition – for him, euthanasia can be performed both by act and by omission. As long as the act or the omission is done with the intention of killing, it constitutes euthanasia. Not all the writers in the book follow him in this assessment. For others like Boyd or Jennett, who follow the Dutch definition of euthanasia as the ‘purposeful acting to terminate life by someone other than the person concerned upon request of the latter’ (Boyd 1998, p.77), euthanasia by omission does not exist. The Walton Report expresses a similar view:

‘11. [...] Our terms of reference address not only euthanasia but also a number of other difficult issues, where similar implications arise.

12. The first part of our terms of reference raises the issue of when it is appropriate to discontinue, or not to initiate, medical treatment. Different considerations inevitably arise in the care of patients who are legally competent and of sound mind and in the case of those who are unable for whatever reason to express their wishes about treatment and are thus incapable of giving valid consent.

13. The second part raises the issue of euthanasia as commonly understood, meaning a deliberate intervention undertaken with the express intention of ending life. This presents the crucial question of whether deliberate killing can ever be justified by the wish of the person killed or by the intention to be merciful.

[...]

20. The word **euthanasia** originally meant nothing more than gentle and easy death. In the context of our enquiry, however, we use it to mean a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering.

21. The term **passive euthanasia** is often used to describe the withdrawal or withholding of some treatment necessary for the continuation of the patient's life.

We consider this term to be misleading [...]. We therefore speak of **withdrawing or not initiating treatment** or of a **treatment-limiting decision**' (Walton Report 1998, p.98/99).

In the Walton Report, euthanasia and treatment-limiting decisions are dealt with as two separate issues (though both as part of medical care). Treatment-limiting decisions might be 'difficult issues, where similar implications arise' (see above), but they are not just grouped together as euthanasia by omission, or passive euthanasia, with active euthanasia, or euthanasia by act.

We now have two opposing viewpoints: one holds that all acts and omissions with the intention to kill are to be called euthanasia and talked about as one single issue, the other one implies that all acts with intention to kill are to be called euthanasia, whereas omissions are not to be considered as constituting euthanasia, regardless of intention, and therefore have to be discussed as a separate issue. The philosopher Boyle takes up this issue:

It seems clear that withdrawing life-sustaining treatments can be a way of killing people, particularly when they are deliberately withdrawn for the sake of ending the patient's life (Boyle 1992: 35-37). Some have denied this, but at the high price of attributing to the distinction between intentional actions and omissions with identical intentions a moral significance with no rational foundation (Finnis 1993: 331-333).

There surely is a rational basis for distinguishing some decisions to withdraw life-sustaining treatments from actions (and omissions) chosen for the sake of ending life. But this does not justify attributing moral significance to the mere behavioural difference between actions and omissions, or between killing and letting die just as such (Grisez & Boyle 1979: 414-419) (Boyle 1998, p.197).

This third viewpoint holds that instead of only two there are three categories: euthanasia by act, euthanasia by omission, and omissions that do not constitute euthanasia. The key concept in distinguishing between the latter two is intention.

The concept of intention

Even if there was agreement over the establishment of those categories and terms, that does not mean that there is no dispute over the assignment of cases to the categories. The term 'intention' is agreed to be the key concept that assigns cases to the different categories, but the meaning of the concept is not universally agreed. Accordingly, different people could assign the same case to different categories in the shared classification system. Keown in his chapter about 'Euthanasia in the Netherlands' discusses the Rummelink study, which was carried out by a commission set up by the Dutch government to investigate the 'extent and nature of medical euthanasia practice'. The survey 'embrace[d] all medical decisions affecting the end of life so that euthanasia could be seen within that broader context' (hence the umbrella term 'medical decisions concerning the end of life') (Keown 1998b, p.266). In asking doctors about their action, they asked not simply whether they intended to kill the patient or not, but asked for a more complex description of their state of mind:

'The authors of the Survey distinguish the following states of mind:

[acting with] the explicit purpose of hastening the end of life;

[acting] partly with the purpose of hastening the end of life;

[acting while] taking into account the probability that the end of life will be hastened.

They explain that the first category, unlike the third, applied where the patient's death was the intended outcome of the action. The second category was used because sometimes an act was performed with a particular aim (such as pain relief) but the side effect (such as death) was 'not unwelcome'. The authors felt that such an effect should be categorised as intentional because to count as *unintentional* a death 'should not in fact have been desired'. The category related to a situation in which the 'death of the patient was not foremost in the physician's mind but neither was death unwelcome' and was regarded by the author as a 'type' of intention (Keown 1998b, p.271).

Keown does not agree with this definition of intention, as 'their apparent understanding of the concept of 'purpose' [or intent] in fact leave[s] the matter unclear' (Keown 1998b, p.272) – meaning the authors of the Rummelink study would assign cases to the category of intentional killing that he would not - and the other authors of 'Euthanasia examined' seem to be in agreement with him. The clear idea that they all accept is that intention is the 'purpose', the one reason for carrying out the action. This seems straightforward enough. However, taking a closer look it becomes obvious that there are two different models of what intentions are that sit together uneasily, implied but never clarified: are intentions motives that arise inside the individual and can be discovered and described by him- or herself through introspection? This idea comes to the fore in this quote from Fisher:

'When we ask about intentions we are getting to the heart of our moral character: who we are and what we are about. The difference between intending-and-causing and foreseeing-but-not-intending is not always easy to discern, and people's intentions are often as confused as their motives are mixed. But for the most part what is intentional is not in doubt, and various questions and what-if tests can be used to clarify intentions' (Fisher 1998, p.324).

Or can intention easily be read by the external observers of an action, belonging more to the action than the actor? An example is the idea that to inject a person with a poison like potassium chloride automatically implies the intention of killing, even though the actor could argue that his motivation was ultimately to relieve suffering, not to kill (Dr. Kevorkian uses this argument – see Chapter (5) for his case). Both models get applied. The concept of intention leads us into the tricky area of ‘meanings’. Weber was already struggling with the same issue of meaning as something objective and/or subjective when developing his concept of the ‘ideal type’:

The theoretical concepts of sociology are ideal types, not only from the objective point of view, but also in their application to subjective processes. In the great majority of cases actual action goes on in a state of inarticulate half-consciousness or actual unconsciousness of its subjective meaning. The actor is more likely to ‘be aware’ of it in a vague sense that he is to ‘know’ what he is doing or be explicitly self-conscious about it. In most cases his action is governed by impulse or habit. Only occasionally and, in the uniform action of large numbers often only in the case of a few individuals, is the subjective meaning of the action, whether rational or irrational, brought clearly into consciousness. The ideal type of meaningful action where the meaning is fully conscious and explicit is a marginal case’ (Weber 1964, p.111/112).

Weber’s ‘ideal type’ goes in the right direction of bringing the two models of meaning (or intention) together. However, it relies on the construction of a concept that is rather difficult to square with empirical reality, because of Weber’s explicit insistence on its abstract nature. In a sense, he relies on the ideal typical meaning/intent as described by the sociologist, interpreted by reading from the action, to be more real than the meaning/intention as voiced by the actor, when probed for it. This puts too little emphasis on the fact that the sociologist is part of his social field and constructs his ideal type from within that field.

C. Wright Mills has a slightly different approach to the topic. He starts from the solidity of motives as opposed to the vagueness of meaning or intention. He says:

‘Motives are words’ (Mills 1963, p.441). The issue is not intention as read from actions, but (more narrowly) motives about their actions voiced by the actors. In his words:

‘As over against the inferential conception of motives as subjective ‘springs’ of action, motives may be considered as typical vocabularies having ascertainable functions in delimited social situations [...]. The differing reasons men give for their actions are not themselves without reasons’ (Mills 1963, p.439/440).

In other words: individuals can explain their motives to themselves and others only by reference to socially existing and acceptable vocabularies of motive. Meaning, or intention, also and especially on the individual level, is an inherently social concept. We can see that the subjective (from within) and objective (from without) conception of intention are inherently linked and related, and that different sociologists have developed theories of how exactly that relation has to be thought.

The authors of the Remmelink study conceive of intention as states of minds of individuals. The authors of ‘Euthanasia examined’ switch between conceiving of intentions as relatively stable attributes of particular actions (the action of injecting potassium chloride gets linked with the intention to kill, not the intention to relieve suffering – this is implied for example in the contribution from Gormally) and as individual states of mind (see the contribution from Fisher on intentions as arising within a person). The tension is not resolved, not stated or explicitly recognised. There is certainly no attempt to resolve this tension, as in Weber and Mills.

Intended and foreseen consequences of action

So far, euthanasia is defined as an action (act and/or omission) resulting in death, and the criteria for calling this action euthanasia is intention to kill. This is the narrow definition of euthanasia that all contributors to Keown agree with (at least with respect to intention). However, some writers attempt to broaden this definition to include not only actions that intend death but all actions that bring about death. We are now getting into a discussion about whether there are acts that kill but do not constitute euthanasia. This would add a

fourth category to our three categories of euthanasia by act, euthanasia by omission and omissions that are not euthanasia. There is one act in particular that is discussed in relation to those issues: the injection of pain killing drugs like morphine or diamorphine. The concept of the 'double effect' first of all implies a belief that drugs given with the intention of pain relief can sometimes hasten the death of the patient (although hospice doctors like Twycross (1998, p.162) hold that the knowledge of experts in pain relief has extended so far that this need not be the case nowadays). Among those who believe in the potential of pain-relieving drugs to hasten death as a side-effect, there is disagreement as to whether there is a difference between intending and foreseeing death. Finnis believes that there is definite distinction:

'Intention is a tough, sophisticated and serviceable concept, well worthy of its central role in moral deliberation, analysis and judgement, because it picks out the central realities of deliberation and choice: the linking of means and ends in a plan or proposal-for-action adopted by choice in preference to alternative proposals (including: to do nothing). What one intends is what one chooses, whether as end or as means [...]. The distinctions between what is intended as a means or an end and what is excepted as a side-effect do not depend upon whether the side-effect is desired or undesired, welcomed or accepted with reluctance. Provided that one in no way adjusts one's plan so as to make them more likely, side-effects may be welcomed as a 'bonus' without being intended' (Finnis 1998a, p.26/27).

In contrast, Harris argues that

'it is more plausible to think of our moral responsibility as covering what we knowingly and voluntarily bring about [...]. What makes causing the death morally permissible either intentionally or knowingly, is whether or not the person should die, not whether or not their death should be intended or merely foreseen as a consequence [...]. If someone should die in these circumstances then their death should neither be intended nor brought about voluntarily though not intentionally. If they should not die, if causing their death would be unfair and unreasonable or even

downright wicked, then it would be equally wrong to bring it about intentionally or voluntarily (Harris 1998b, p.38/39).

In Harris' view, all actions that result in death constitute killing, or constitute euthanasia. For that, he does not need to rely on the view that death needs to be at least partly intended, as the Rummelink authors hold and as Finnis seems to imply that Harris did when he argues that desire is not the same as intention. He argues that the knowledge that death might happen as a result of a proposed action is enough for the action to be unacceptable. But what do we know? It seems that some of those controversies could be solved if people agreed whether, in relation to pain relief, we are talking about death as a rare side-effect that could happen, or as a foreseen consequence that must happen. Harris' argument surely relies on the latter – if he would hold it also to be correct if the former applied, he would effectively be saying that every action that could conceivably lead to a death was unacceptable, including for example most surgical interventions or vaccinations. To those that believe in and accept the validity of the 'double effect', the giving of pain-relieving drugs is associated with an intention to relieve suffering, not to kill. Here, a particular intention becomes linked to a particular action. A vocabulary of motive for a particular social situation is being established. Yet, if one holds that pain-relieving drugs can also kill, there must still be room for possibility that a(n) (over-)dose of pain-relieving drugs could be given with the intention to kill. People like Harris who attack the concept of the 'double effect' are really attacking the fact that the giving of pain-relieving drugs seems to become completely and blankly dissociated from any intention to kill. However, as we have seen, Harris goes a lot further than this in his statement that foreseen consequences are no different from intended consequences, and that therefore deaths resulting from them are to be seen as deaths from euthanasia.

Treatment and care

Earlier it was noted that some writers defend the existence of a category of omissions that are not done with the intent to kill, and thus do not constitute euthanasia. In this section I will look more closely at how this category is argued about in relation to medical

treatment and care. Omissions generally refer to the withholding or withdrawing of medical treatment. The first question then is whether it is ever justified to withhold or withdraw medical treatment. Gormally argues that it is, starting from

‘[...] a clear understanding of the limited purpose of medicine. The purpose of medicine is the restoration and maintenance of health (or of some approximation to health) or the palliation of symptoms [...]. One implication of this understanding of the purpose of medicine is that if a living human body has been so severely damaged that it no longer makes sense to speak of a continuing capacity to share in human goods other than life itself, then what is integral to what we value in health is no longer achievable. But once the good of health, so understood, ceases to be achievable doctors are under no obligation to employ *medical* treatment with a view simply to prolonging life. Prolongation of life is not an independent goal of medicine; it makes sense as long as one can sustain a degree of organic well-functioning sufficient to allow for some sharing, however minimal, in other human goods’ (Gormally 1998, p.117).

Fisher agrees:

‘Thus traditional medical ethics and Catholic morality counsel against over-treatment as well as under-treatment, and allow that some treatments will be withheld or withdrawn for good therapeutic reasons: their continued use may be futile or they may impose such a burden (in terms of pain, indignity, disruption, confinement, risk, cost, etc.) that those concerned judge it disproportionate to the benefit gained’ (Fisher 1998, p.323).

Those two quotes clearly establish the existence of a category of ‘futile treatment’. They hold that it is possible to distinguish futile treatment as treatment that only prolongs life from treatment that does more than that. The existence of the category does not seem to be in dispute. The problem is however the assignment of cases into the two categories. Is it possible in practice to distinguish between ‘futile treatment, that is treatment which was

unlikely or incapable of achieving its normal therapeutic purpose', and 'the withdrawal of treatment which was preserving 'futile' lives, that is, lives which were not thought to be worth preserving' (Keown 1998b, p.277)? The category of 'futile treatment' relies on technical knowledge about treatments and their effect in general and in particular patients. The category of 'futile lives' depends on value judgements and can in principle be extended without limits. The withdrawal of treatment is sometimes argued around the 'best interests' of the patient. This concept refers to the person rather than the treatment, and the confusion that this creates can be seen in relation to the Bland case, where courts had to decide whether to discontinue tube-feeding from a patient in PVS: 'it was held both that death was appropriate because Tony Bland was no longer capable of possessing any interests at all, and that death was in his best interests' (Harris 1998a, p.18). The meaning of the term 'best interests' understood as an 'objective' technical term referring to what is in a *medical* sense the best for the patient shades very easily into a subjective judgement about the person's life.

So far it has been established that the experts agree that there are limits to the duty to provide medical treatment. What about care? Finnis makes this point in relation to people in a Persistent Vegetative State,

'the care to be provided to them need not, I think, be more than is provided (save in times of most desperate emergency) to anyone and everyone for whom one has any respect and responsibility: the food, water and cleaning that one can provide at home' (Finnis 1998a, p.33).

This seems to establish a clear difference between medical treatment and care. Medical treatment can sometimes be withheld or withdrawn, ordinary care cannot. However, Harris quarrels with Finnis about the basis on which the decision between medical treatment and care has been made. Harris, as we have seen, holds that we are responsible for all the foreseen consequences of our actions, and if we know that they might lead to death, we shouldn't do them (unless we have decided that the person should die). Accordingly Harris picks up on what Finnis has said to ask:

‘Would it be legitimate to give such home ‘care’ to someone with a condition in which he would die at home but make a full recovery to normal functioning (my personhood) in ‘hospital’? Certainly to choose the home care is not to treat that individual as the equal of someone treated in hospital. Finnis would admit that such a choice would be unfair and unreasonable. I say it would be unfair and unreasonable *because* it would be to choose to kill the patient [...]. It is also surely self-deception if ‘fair-minded people’ think they are not killing someone when they deliberately choose a regime of treatment which they know will result in the patient’s death, where there is an alternative which will keep the patient alive’ (Harris 1998b, p.43).

Harris holds that patients should always be kept alive - until and unless a decision has been made that they should die. In the case of the PVS patient, when he or she comes home from hospital to receive care, instead of medical treatment in hospital, effectively the decision has been made that this person should die. It is not that Harris argues that one should never make any decisions that lead to the death of a patient; what he argues is that any decision that leads to death, if there would have been something one could have done to prevent this death, constitutes killing. He thus expands the concept of killing to such an extent that Finnis accuses him by saying that what he does is effectively ‘to include decisions by Parliament not to increase the health budget by the sums that would be required to save every life that could be saved – i.e. all decisions to spend money on something other than life-saving. On this basis, he can freely and quite misleadingly denounce ‘the government’s euthanasia programme’’ (Finnis 1998b, p.53). By not making a distinction between actions that kill, actions that might have death as a side-effect and actions that might make it possible for death to occur, Harris waters down the concept of euthanasia to such an extent that it is difficult to see how it could still usefully serve any purpose. However, it does show us that the concept of euthanasia can be applied very narrowly referring to a few very specific circumstances as well as very broadly, encompassing any actions that can in some way be linked to the death of a person.

The Bland case

So far, the discussion has concentrated exclusively on the dos and don'ts concerning doctors providing medical treatment. I will now look at a particular case in order to clarify and bring together the diverse concepts discussed so far and show the struggle over categories and boundaries with respect to the case.

First of all, however, I want to show in a diagram what a plausible classification system encompassing all that has been said so far could look like:

	Extraordinary medical treatment	Ordinary medical treatment	Ordinary care	Active euthanasia
Function and aim of treatment	To substitute lost physiological function (permanently) - only prolong life	To substitute lost physiological function (permanently or temporarily) -restore to health/maintain (some approximation of) health, and/or symptom control (including pain control with substances that as a side-effect could hasten death)	Provision of shelter, personal hygiene, food and drink	
Action evaluated from the perspective of the actor (doctor)	Treatment = burdensome, on balance does more harm than benefit to the patient Discontinue treatment = benefits the patient? (morally permissible, even obligatory?)	Discontinue treatment = does harm to the patient (not morally permissible)	Discontinue care = does harm to the patient (not morally permissible)	For example injection of lethal substance = does harm to the patient (not morally permissible)
Actor's intention in acting	Not to kill	To kill	To kill	To kill
Name given to action	'good medical practice'	'passive euthanasia'	'passive euthanasia'	'active euthanasia'

We have the categories of extraordinary (futile) medical treatment, ordinary medical treatment, ordinary care and active euthanasia. As we have seen, the distinction between extraordinary and ordinary medical treatment is not accepted by everyone. The first three categories refer to treatment or care that has a certain function that does not involve killing. Active euthanasia does not have a function apart from killing. It is generally accepted that care cannot just be discontinued. There is an obligation to house, clothe and feed people one has responsibility for. Those who make a distinction between extraordinary and ordinary medical treatment hold that the first can be discontinued, the

second cannot. Those that do not make a distinction, and only differentiate between medical treatment and care, either hold that medical treatment can never be withdrawn or withheld (extending to what others would call extraordinary medical treatment), or argue that there are circumstances in which medical treatment can be withheld or withdrawn (extending to what others call the category of ordinary medical treatment)³. Whether the diverse actions constitute killing, or good medical practice, passive or active euthanasia consequently depends on how one thinks about those categories of treatment and care.

The case I would like to turn to now is the case of Anthony Bland. Bland had been in a Persistent Vegetative State for several years when in 1992 his parents went to court to request that tube-feeding be discontinued. Patients in PVS breathe independently and with tube-feeding and ordinary care they can survive sometimes for decades, without ever regaining consciousness. The judges all agreed that tube-feeding is medical treatment and can be withheld. The Bland case is discussed at several instances in 'Euthanasia examined', and the interpretations of the judgement differ according to the views of the authors. Here I only want to show the controversies that the decision of the judges aroused in terms of the diagram.

Tube-feeding or the giving of nutrition and hydration by tube can be considered as either extraordinary treatment, ordinary treatment or ordinary care. People who think and talk about tube-feeding as the provision of 'food' and 'drink', hold that it constitutes ordinary care which can never be withheld from another human being. To do so would be killing, or passive euthanasia. If one thinks that tube-feeding (the artificial provision of nutrition and hydration) only prolongs life, with no other purpose, one could think of it as extraordinary medical treatment which can be withdrawn, without constituting killing or euthanasia. The judges however did not talk about extraordinary versus ordinary treatment, they talked about 'medical treatment' versus care. That means that their decision could be (and has been) interpreted as allowing the withdrawal of ordinary treatment (for example by Harris: 'their decision was in effect one of permitting non-voluntary euthanasia' (Harris 1998a, p.18)), which means that they effectively legalised

³ A distinction could be made between withholding and withdrawing treatment – I have not included it in my discussion or the diagram for the reason that it does not seem relevant here and is hardly ever referred to, at least in this Britain. It is sometimes said that withholding is emotionally easier than withdrawing, but

an act of passive euthanasia, or deliberate killing. The judges themselves denied that, probably thinking about 'extraordinary medical treatment' but talking about 'medical treatment' in general. This has led to a situation in which people disagree whether the law has changed since the Bland case or not, regarding passive euthanasia. As we have seen earlier, the Walton Report (written by the House of Lords Select Committee on Medical Ethics which was established in reaction to the ruling on the Bland case) holds that the withdrawal of medical treatment does not constitute euthanasia by omission, or passive euthanasia. It should become clear now that a division of the category 'medical treatment' into 'extraordinary' and 'ordinary treatment' could go a long way to solving the above controversies (in terms of the establishment of logical categories, if not in the assignment of cases to categories). To assign the Bland case to the category of extraordinary treatment would make it possible, in the light of the judgement, to still defend the notion that doctors have a duty to provide and not to discontinue ordinary treatment.

What is the 'central case' of euthanasia?

Until now, the discussion, or at least the line I have explored, is that euthanasia, active or passive, is something that doctors should not do. The judges in the Bland case hold the same view when they allow Tony Bland to die but do not call it euthanasia. The people who disagree with the outcome of the Bland case call it a case of euthanasia, implying that euthanasia is wrong and should not be allowed by law. However, there is a third category of people who argue that the Bland case has effectively legalised a form of euthanasia, and they welcome that. These are people who do not necessarily hold that euthanasia is something that doctors should never do.

Let us go back to some definitions:

'As I shall define the term, *euthanasia* is the implementation of a decision that a particular individual's life will come to an end before it need do so – a decision that a

that if one allows withholding and not withdrawing, there is the danger that treatment regimes that could lead to positive results might never be tried.

life will end when it could be prolonged. This decision may involve direct interventions (active euthanasia) or withholding of life-prolonging measures (passive euthanasia). If the decision coincides with the individual's wishes and he or she has consciously and expressly approved of the decision, I will call this *voluntary euthanasia*. Where the individual concerned does not know about the decision and has not consciously and expressly approved it in advance, I will call this *non-voluntary euthanasia* even where he or she is believed or presumed to be in accord. I shall not, for the most part, be concerned with involuntary euthanasia or murder where the individual is presumed or known to wish to go on living' (Harris 1998a, p.6/7).

'A standard definition of 'euthanasia' is 'the intentional putting to death of a person with an incurable or painful disease'. It is common to refer to euthanasia carried out by an act as 'active' euthanasia and euthanasia by omission as 'passive' euthanasia. A common further sub-division is between 'voluntary', 'non-voluntary' and 'involuntary' euthanasia, which refer respectively to euthanasia at the patient's request, where the patient is incompetent, and where the patient is competent but has made no request' (Keown 1998b, p.263).

'23. The state of mind of the person whose death might be brought about by an act of euthanasia, as we have defined it, is of course significant. **Voluntary euthanasia** occurs when the patient's death is brought about at his or her own request. **Non-voluntary euthanasia** may be used to describe the killing of a patient who does not have the capacity to understand what euthanasia means and cannot therefore form a request or withhold consent. **Involuntary euthanasia** has been used to describe the killing of a patient who is competent to request or consent to the act, but does not do so' (Walton Report 1998, p.100).

We have dealt with the first part of the definition of the concept of euthanasia, involving the question of acts and omissions. The question of acts and omissions is important from the doctor's point of view in terms of what is considered to be the boundaries of good

medical practice that he or she should aspire to deliver – and also from the patient’s point of view in the sense of how he or she can generally be expected to be treated. Here, the doctor is the agent and the patient the passive receiver. A further extension to the definition of the concept makes room for the possibility of the patient assuming a more active role in his treatment. The introduction of the patient perspective forces us to amend the diagram used above:

	Extraordinary medical treatment	Ordinary medical treatment	Ordinary care	Active euthanasia
Function and aim of treatment	To substitute lost physiological function (permanently) - only prolong life	To substitute lost physiological function (permanently or temporarily) -restore to health/maintain (some approximation of) health and/or symptom control (including pain control with substances that as a side-effect could hasten death)	Provision of shelter, personal hygiene, food and drink	
Action evaluated from the perspective of the actor (doctor)	Treatment = burdensome, on balance does more harm than benefit to the patient Discontinue treatment = benefits the patient? (morally permissible, even obligatory?)	Discontinue treatment = does harm to the patient (not morally permissible)	Discontinue care = does harm to the patient (not morally permissible)	For example injection of lethal substance = does harm to the patient (not morally permissible)
Actor's intention in acting	Not to kill	To kill	To kill	To kill
Name given to action	'good medical practice'	'passive euthanasia'	'passive euthanasia'	'active euthanasia'
Action evaluated from the perspective of the receiver	Does the request by the patient make any difference to the moral evaluation and permissibility of the action?	Does the harm become a benefit and the action morally permissible if requested by the patient?	Is the provision of care an offer that can be declined? (personal hygiene can be imposed. . .)	Does the harm become a benefit and the action morally permissible if requested by the patient?

The introduction of the new component to the definition of the concept of euthanasia – the patient – begs the question of whether actions that doctors generally should not perform become permissible if the patient asks for them.

One could start by saying that only a patient who is competent can be active. If he or she wishes for euthanasia, the action would be called 'voluntary euthanasia'. If he or she does not want to be killed, that would constitute 'involuntary euthanasia'. An incompetent person cannot make a decision: to kill him or her would be to perform 'non-voluntary euthanasia'. However, there is some discussion in the Keown book and beyond as to how an incompetent person could take some active part in their treatment through an advance directive or living will, where they could spell out their wishes when still competent, to apply in the case of them becoming incompetent, which in principle could include asking for euthanasia. There are a range of controversies around this concept that I will not spell out here and now (see Hornett and his chapter on advance directives in Keown 1998). Only one thing is important to remember at this stage: active euthanasia in all senses is illegal and under British law constitutes murder. In practice, advance directives are not legal documents that bind doctors to follow them, but are currently seen as guidelines only that help doctors in their decision-making through knowledge of the wishes of the individual. Advance directives can only reject treatment, not ask for treatment - just as competent people can reject any treatment for any reason (even for what could be judged irrational or non-existent reasons, even if this rejection leads to death (Hornett 1998, p.299 and p.304)), but cannot ask for particular treatment, especially not illegal actions like euthanasia.

This subdivision into voluntary, involuntary and non-voluntary euthanasia is common currency. All the writers in Keown use those categories, but the status of the boundaries between them is heavily contested. There are essentially two positions. One holds that voluntary euthanasia is something radically different from non-voluntary and involuntary euthanasia, because it is done on request of the patient. The request of the patient, patient autonomy and respect for that autonomy are central to this argument. It is the argument put forward by the voluntary euthanasia movement, a movement that has grown in strength over the last decade, has growing public support and is represented in Britain by the Voluntary Euthanasia Society (VES and VESS of Scotland). Jean Davies of the VES represents their agenda in a chapter in 'Euthanasia examined':

‘As its name implies, the voluntary euthanasia movement is not concerned with involuntary euthanasia. The arguments supporting the former are very different from those that would justify the latter. Legislation proposed by those who want the choice of voluntary euthanasia to be available would sharply distinguish between them and confine itself entirely to medical help to die given at the patient’s considered and enduring request’ (Davies 1998, p.84).

The VES is not concerned with non-voluntary and involuntary euthanasia. Unlike medical and legal philosophers who start their thinking about euthanasia from the position of the doctor and have to consider the whole universe of treatment, the VES as a lobby and pressure group speaking for the rights of the patient only need to press their particular point. They want people to be able to have a choice in when and how to die, and forms of euthanasia that don’t involve patient choice are simply not their concern. They press for the legalisation of voluntary euthanasia and are convinced that the practice of other forms of euthanasia, still being illegal, still being crimes, need not and would not follow. The central concern of voluntary euthanasia is the request, which is absent from non-voluntary and involuntary euthanasia. In the Netherlands, where euthanasia has gone through a process of decriminalisation for the last 20 years and finally been legalised in November 2000, the word ‘euthanasia’ actually means ‘voluntary euthanasia’ in our terms:

‘Dutch definitions of ‘euthanasia’ are, typically, markedly narrower, such as ‘the purposeful acting to terminate life by someone other than the person concerned upon request of the latter’. It will be apparent that this is narrower than the usual definition in two respects: it is limited to cases of *active* killing where there is a *request by the patient*. In short, the Dutch definition corresponds to what is normally called ‘active, voluntary euthanasia’ (Keown 1998b, p.263).

So it is ‘normal’ in Britain to group together through language actions of killing on request and killing without knowledge of or against somebody’s wishes, calling them all ‘euthanasia’ and differentiating between them only through a qualifying adjective, thus

representing the perceived kinship between the concepts - whereas in the Netherlands the language embodies the perception that 'euthanasia' and other actions by doctors on patients that lead to the latter's death are something different.

Language is important in that it shapes our thinking about the world and the concepts embodied in language engender associations and separations between different entities – which may be different in different languages⁴. If different actions are all called 'euthanasia', they must have something in common. We have seen that the first position holds that there is a strict boundary between voluntary euthanasia and other kinds of euthanasia. The second position argues that the different forms of euthanasia have something in common that is so central that the boundaries between them are weak or almost non-existent. Finnis for example defends this latter position:

'So I define the *central case* of *euthanasia* as the adopting and carrying out of a proposal that, as part of the medical care given someone, his or her life be terminated on the ground that it would be better for him or her (or at least no harm) if that were done' (Finnis 1998a, p.24).

⁴ Margaret Pabst Battin has looked at language in relation to physician-assisted suicide. She makes the interesting point of how different cultural attitudes to assisted suicide in Germany as compared to the Anglo-American world can be found in the German language and law, as compared to the English. For one thing, suicide was decriminalised in Germany in 1751, while it remained an offence in England until 1961. This in itself can be argued to have arisen out of a cultural acceptance of suicide unknown to the Anglo-American world, as can be derived from the fact that while the English language knows one term, 'suicide', German knows at least four, one of which – 'Freitod', literally 'free death' – is a positive term: 'free from connotations of either moral wrongness or pathology [...] it is associated with voluntary individual choice and the expression of basic, strongly held personal values or ideals, especially those running counter to conventional societal norms, and suggest the triumph of personal integrity in the face of threat or shame. Freitod has an archaic flavour, often associated with Romanticism, and would not generally be used in ordinary conversation; however, it is readily recognisable to most German speakers' (Battin 1994, p.261). As Battin continues, 'the only English terms for suicide that do not have negative connotations carry either pronounced religious associations or the implication that the suicide serves the interest of some other person or cause: these are terms like self-sacrifice or martyrdom. The very concept of Freitod – a notion without religious, altruistic overtones and without negative moral or psychological implications, but that celebrates the voluntary choice of death as a personal expression of principled idealism – is, in short, linguistically unfamiliar to English speakers' (Battin 1994, p.263). However, Freitod is only one version of suicide – the most common term, 'Selbstmord' (literally 'self-murder'), refers to a tragic act, associated with despair, anger and depression, and Germany puts much effort into suicide prevention to reduce the occurrence of those tragic acts. This shows how language is instrumental in reflecting and shaping our thinking about the world.

The argument runs as follows: the doctor is the one who does the killing. He or she can never be conceptualised as a medical automaton but has to be seen as a moral agent with his or her own reasons for doing or not doing things. So even if it is the patient who requests to be killed, the doctor must at least make the patient's judgement her own that the patient would be better off dead, or that his life was no longer worth living, in order to carry out the action. This judgement becomes the doctor's judgement, if it was not her own judgement in the first place. Even if this judgement is seen as benign because merciful in particular cases, there is nevertheless no reason why the doctor cannot extend that judgement to incompetent people or people who could ask for euthanasia but do not. Finnis argues that in principle there is no difference between the different forms of euthanasia, and that accordingly voluntary euthanasia should not be allowed, indeed that no form of euthanasia should be allowed. One should never kill a person out of respect for their life (he distinguishes his position from the argument of the slippery slope which holds that a conceptual difference can be made between voluntary and other forms of euthanasia *in principle*, but that if voluntary euthanasia became legal, *in practice* killing would be extended to other patients who cannot or do not ask).

Voluntary euthanasia

The case of the Voluntary Euthanasia Society on the other hand rests on patient autonomy:

‘Today, most people do aspire to make their own choices about education, career, marriage and lifestyle. They see no reason why they should not at the end of life choose a quicker death with less suffering if that blessing seems likely to be denied to them’ (Davies 1998, p.87).

Yale Kamisar, who writes about the United States, argues that there at least, autonomy has become the main argument, above and beyond pain and suffering:

‘Autonomy, not pain or its merciful alleviation, is the principal and even sole justifying argument offered by modern proponents. Opponents who argue [...] that modern methods of pain control can virtually eliminate the category of ‘intractable’ pain are correct enough, but they miss the mark: the right to choose death, not the presence of pain, is now the issue’ (Kamisar 1989, p.236).

As many opponents of the practice of voluntary euthanasia tend to point out, individual autonomy has limits. Finnis puts it this way: ‘autonomy is indeed a great good. But its exercise should be consistent with the rights of others and with all the other requirements of humane and decent behaviour’ (Finnis 1998c, p.70). However, the recognition of this fact is not lost on the proponents of voluntary euthanasia either, as can be seen from the language they use: patients should be allowed to *request* euthanasia. They should not be enabled to *demand* from the doctor to be killed (this might be a tactical concession, but it is nevertheless the convention). The basic principle that justifies voluntary euthanasia in their view is patient autonomy, but they recognise that autonomy has its limits. This means that they also recognise that ultimately it will be the doctor (it could also be a court) who decides whether to honour the request. This leads us back straight to Finnis who holds that ultimately euthanasia comes down to the judgement of the doctor.

The problem for the Voluntary Euthanasia Society, and others who think about the legalisation of voluntary euthanasia, is that they have to establish certain categories of patients whose requests are generally seen as valid ones (and which in principle would be honoured), as well as criteria that specify which ones among those individual requests will be granted – if the judgement should not be the doctor’s alone. Kenneth Boyd for example is thinking along those lines:

‘[...] there are at least three groups for whom voluntary euthanasia *may* be justified. They are (1) those, not necessarily near death, but who are totally paralysed and respirator dependent; (2) others, within weeks or months of death, who have either extreme difficulty in breathing or other very distressing symptoms, not necessarily painful, which cannot be relieved; and (3), more controversial, people with dementia, some insight, and who have explicitly requested euthanasia if these circumstances

should arise. No less disturbing, to complicate this picture, are all the people whose needs and wishes *could* be met without euthanasia but *are* not, because of a lack of resources, time or skill' (Boyd 1998, p.77).

Boyd tries to establish categories of people who may ask for euthanasia. Whether their individual requests will be granted is another matter. Boyd does not establish formal criteria for this latter judgement, for he holds that 'a new set of ethically and intellectually consistent rules' is, I think, probably asking too much from human nature' (Boyd 1998, p.80). What he does instead is to propose to improve the communication between doctor and patient, and to resolve the matter in conversation:

'At those times when a request for euthanasia *may* be morally justified, the closest we can get to determining whether it *is* morally justified is the kind of conversation where, in Derrida's terms, one addresses 'oneself to the other in the language of the other', or to repeat Simone Weil's words, 'each of one of them, without ceasing to think in the first person, really understands what the other also thinks in the first person'' (Boyd 1998, p.79).

Boyd's three groups of people for whom euthanasia, as he says, may be justified are quite specialised and narrow. This need not necessarily be so. Some argue that euthanasia for terminally ill people may be justified, but not for people with chronic illnesses. Or, euthanasia for some chronic conditions may be justified but not for others. Or, people with severe physical disabilities may be included or excluded. There is no definite time boundary between conditions that are terminal or not terminal, and no congruence between the subjective and objective perception of suffering. Any groups that are set up have to be set up by convention, which cannot claim to rest on inviolable objective facts. Boyd holds that the judgement whether euthanasia is justified in the individual case rests on an in-depth conversation between doctor and patient, maybe involving others like relatives or friends, which should lead to consensus on the issue. The general first step in assessing the individual case is the assessment of the competence of the patient: only a person who is judged to be competent can make a valid request. Here, we are only

concerned with voluntary euthanasia, that is patients who are conscious and can make a request. But even a patient who makes a request can be judged to be unable to really understand what he or she is asking. This patient would be judged to be incompetent, and automatically not eligible for euthanasia. In a competent patient, the assessment then may be extended to:

‘The methodical exploration of underlying issues in patients [leading to the request of euthanasia]:

- adequacy of pain and symptom management;
- the psychological status of the patient, with particular reference to depression;
- the context and meaning of the request to the patient.

Psychological well-being is impossible if the patient is troubled by severe physical symptoms. Satisfactory symptom control is of paramount importance. No patient should be forced to request euthanasia because of unrelieved pain or other distressing symptoms such as vomiting or shortness of breath. Methods exist to control such symptoms, either completely or to a great extent [...]’ (Twycross 1998, p.146/147).

If the majority of those symptoms (physical or psychological) can be recognised and managed, and the social context be looked into and improved, will there be any reason left that would justify granting a request for euthanasia (if that request continues to persist)? Probably not, and this is no coincidence, for the quote above comes from a text of a hospice doctor, Dr. Twycross. The hospice philosophy is built on the idea that euthanasia is unnecessary, because pain and other symptoms that accompany terminal illnesses can today be adequately controlled or at least managed. The ‘double effect’ which allows the giving of pain-relieving substances, even taking into account that this might hasten death slightly, makes hospice practices possible. The ideal of hospice is to allow people to die, refraining from interventions that only prolong life and without hastening death in any direct active way (as opposed to what some may call the indirect way covered by the ‘double effect’). There are supposedly always alternatives to euthanasia when suffering is not physical but psychological, spiritual or social, due to

feeling of isolation, fear or anxiety. In the exceptional cases where physical pain is excruciatingly bad and cannot be relieved, sedation is preferred to euthanasia. To sum up, even proponents of voluntary euthanasia do not believe that everybody should be allowed to request euthanasia and that every single request should be granted. Their starting point is the autonomy of the individual patient, accepting that this autonomy is limited. They accept that doctors should have the power to make the assessment as to whether euthanasia is justified in the individual case. But some doctors argue that there are no reasons any more that justify euthanasia, regardless of whether patients still hold on to their wish to die after all attempts to convince them otherwise or not. We have come full circle. If it is down to the doctor's judgement whether euthanasia is justified, this judgement rests on the doctor's opinion about whether the patient would be better off dead. There is not much left of autonomy and self-determined dying. As we can see, it is incredibly difficult to set up some rules around voluntary euthanasia. The autonomy of patients and the ultimate decision resting with the doctor are not compatible. The struggle over whether there is a solution to that problem is ongoing. One possible solution to the problem that is being promoted is physician-assisted suicide. Dieter Giesen defines the difference between active euthanasia and assisted suicide from the point of view of the law as follows:

‘The difference between active euthanasia and aiding in a terminally ill patient's suicide is essentially that between perpetrators and accessories. In the former case the doctor determines the eventual course of action, whereas in the latter case he merely assists the patient to realise his autonomous decision to end his life. It must be emphasised, however, that while suicide may be looked upon as an act of self-determination and autonomy, active euthanasia cannot. Thus, in almost all legal systems, while active euthanasia remains a punishable offence, suicide has generally been decriminalised, although there remain strong ethical and public policy considerations against its permissibility’ (Giesen 1998, p.206).

In Britain, suicide has been decriminalised but assisted suicide is illegal and can carry a prison sentence for up to 14 years. In Germany however, there is no law covering assisted suicide.

Physician-assisted suicide is primarily being debated in the US, where there is a strong emphasis on autonomy in terms of a 'right to die', which has been interpreted in all kinds of ways with reference to the American Constitution. There have been several court cases and the rulings have been contradictory, from establishing to denying the existence of such a 'right'. Yale Kamisar takes up this issue in his chapter in 'Euthanasia examined'. He argues that:

'Assisted suicide falls somewhere between the termination of life support and active voluntary euthanasia [...]. Active voluntary euthanasia occurs when a person other than the one who dies performs the last act – the one that actually brings about death. Assisted suicide takes place when another person provides assistance but the suicidant commits the last act herself. Although the two practices differ with respect to who performs the 'last act', they are similar in that each involves the active intervention of another person to promote or bring about death' (Kamisar 1998, p.228/229).

While Giesen establishes a definite boundary between active euthanasia and assisted suicide, understood in terms of the autonomy of the patient, Kamisar argues against such a boundary. For him, concentrating on the actions of the doctor rather than the patient perspective, it is not clear that there is a real difference between the two actions, for 'each involves the active intervention of another to promote or bring about death' (see above). His argument relies on his view that the 'real' boundary that should not be crossed is the one between acts and omission. We can see that just as with euthanasia, there is no agreement over physician-assisted suicide.

Non-voluntary euthanasia

Non-voluntary euthanasia is defined as euthanasia performed on a patient who is incompetent. Competence, however, is a judgement by a doctor made about the state of mind of another person. A person who is unconscious is incompetent, whether temporarily (while in a coma) or permanently (as is assumed for people in PVS). A person who is conscious and can voice a request can be judged to be incompetent according to ideas about whether he or she really is capable of understanding her decision, again that could be a permanent state (in mentally handicapped people) or a temporary one (in mentally ill people during a psychotic episode or people with dementia who still have flashes of insight into their condition). It seems that the case for voluntary euthanasia would exclude non-voluntary euthanasia. However, as we have seen in relation to advance directives, attempts are made to extend the autonomy of people who were previously competent to the time when they might have become incompetent. Voluntary euthanasia thus might expand to some incompetent people. Sometimes even claims by relatives or friends as to their knowledge of the patient and what he or she would have wanted can be seen to be enough to expand the concept of voluntary euthanasia to incompetent patients.

Generally, however, proponents for voluntary euthanasia are not concerned with non-voluntary euthanasia. They might hold that it is an important issue that one has to think about, but nothing to do with euthanasia (in the Dutch sense and as the Dutch argue). Opponents might hold that the proponents' view of non-voluntary euthanasia may be a clue as to their 'real motives', for if they are in favour of non-voluntary euthanasia, they can only be so based on a judgement that there exist people who would be better off dead. This judgement can extend even to competent people who do not want to die (involuntary euthanasia). That would prove the case of the opponents, at least in their own terms. Thinking about non-voluntary euthanasia, everything applies that has applied to the discussion as euthanasia as part of medical care – different authors have different ideas as to what counts as euthanasia. They also have different ideas as to what is acceptable. One question was whether ordinary care can be withdrawn – does that constitute (passive)

euthanasia, and if it does, is it acceptable? Another question is whether compassion can ever justify the active killing of an incompetent person.

Harris is arguing that non-voluntary euthanasia may be justified in some cases. He bases his whole argument on the distinction between persons and non-persons. Persons who are competent can be killed in accordance with their wishes (voluntary euthanasia) and against their wishes (involuntary euthanasia). He argues that voluntary euthanasia may be justified, and that involuntary euthanasia can never be justified. Persons can also be incompetent and receive non-voluntary euthanasia. Non-persons are never competent and can receive non-voluntary euthanasia. He makes a distinction in that he holds that non-voluntary euthanasia in persons is never justified, whereas in non-persons it can be justified but does not have to be (according to the balance of benefits for the non-person with the burdens for the persons caring for him or her). His argument hinges on the definition of what a person is: *'a person is a creature capable of valuing its own existence'* (Harris 1998a, p.9) – 'here of course the term 'person' is used to denote a particular sort of individual identified by its capacities or powers rather than by its species membership. On this account persons will constitute a large category of beings, including most humans from an early age, and perhaps also some animals' (Harris 1998a, p.8). The concept of 'person' has been immensely criticised as a concept that comprised both more (including some animals) and less (excluding some humans) creatures than the concept of humanity. The majority of other writers draw the boundaries around humanity rather than around personhood. The problem with drawing boundaries within humanity is to establish several categories of human beings, persons and non-persons, but from the establishment of those categories it does not follow which human beings with which attributes will be assigned to each category. This is the main criticism with that concept, that the meaning of the category of non-person can be expanded very easily. Harris argues that demented people are generally belonging to the category of persons, while Finnis sees them as fitting easily into the category of non-persons. According to Harris, the kinds of human beings that fit into his category of non-persons are very limited. It includes people in PVS – thus he argues that non-voluntary euthanasia can sometimes be justified for people in PVS. We have seen earlier that Harris classifies all decisions that might lead to death as euthanasia. We have also seen that if one made a distinction

between extraordinary treatment and ordinary treatment, it is possible to make decisions of treatment withdrawal that allow people in PVS to die, without having to cross the line to performing non-voluntary euthanasia. There seems to me to be a lot less potential danger for people in making distinctions between types of treatment than between types of people. It might seem insubstantial what we call decisions that lead to death, whether we call them euthanasia or treatment-limiting decisions, as long as they remain the same actions with the same results. However, I must argue that one has to look at the whole interlocking system of classification of words and their meanings and their relation to actions, to be able to make a logical case for or against the performance of certain actions. Doctors who perform those actions have different ideas about what they represent. So do patients. It is vital to gain an overview of the whole system. I have attempted in this chapter so far to describe the system by showing where conflict over categories and boundaries arises. At the same time, by sorting out the categories, in order to make sense of them in a logical way, I can also be said to have created a particular classification system which is partial to a certain point of view. A representation of representations cannot be completely value-free. However, I have tried to be as factual as possible.

The 'facts'

I have said in the introduction that I would say something about the 'facts' that the writers of 'Euthanasia examined' make reference to in arguing their cases. By 'facts' I mean bits of knowledge about the real, material world – about the prevalence of ideas and practices. Those 'facts' are established – created rather than found – by empirical studies. Clive Seale's article 'Social and ethical aspects of euthanasia: a review' (1997) gives an overview of the kinds of questions have been asked by empirical studies in relation to euthanasia. The main question, that has been asked repeatedly over many years and in many Anglo-European countries is: what do people think about euthanasia? The respective studies have established that a large majority of the population is in favour of euthanasia, and that support has been rising over the last decades. Also, a slightly smaller proportion (but generally still a majority) of doctors is in favour of euthanasia. This 'fact'

justifies talking about the issue as ‘without doubt, one of the most pressing and profound issues confronting the modern world’, as Keown said in his introduction (see above), for the high support for euthanasia as uncovered in opinion polls clashes markedly with the illegal nature of the practice. Other questions asked go on from here: why is there such big support for euthanasia and why has there been a rise over time? What characteristics distinguish people who are in favour from people who are against the practice? How many people who are themselves ill or suffering are in favour of euthanasia? What are the reasons that lead people to request euthanasia? How many requests do doctors get and how many requests do they honour by carrying out the practice? How many doctors and/or nurses have been involved in practicing euthanasia? The numbers and proportions resulting from those studies are the ‘facts’ that, carefully selected and juxtaposed, are used by writers with a range of views to support their diverse arguments. The ‘facts’ are, however, not always accepted uncritically. In particular the Remmelink Survey and Report in the Netherlands in 1991 has aroused huge controversies as to the terms employed and consequently the meaning of the findings (see Keown 1998b, who develops a critique of both the Remmelink Survey and the Report). ‘Facts’ about the reality of euthanasia as established by social surveys and studies represent an important part of the expert debate on euthanasia. References to social surveys are ever present in the articles brought together in the Keown book – even if the Keown book does not recognise social scientists explicitly as ‘experts’ on euthanasia (judging by its selection of authors that does not include any social scientist).

Conclusion

This chapter started with a brief selective review of the literature available on euthanasia. This literature was divided into four categories: (1) the management and legally oriented literature on euthanasia in different countries; (2) philosophical and ethical literature; (3) literature concentrating on the social dimension of euthanasia; and lastly (4) personal and fictional accounts. This was done in the awareness that these categories overlap and that it is often not easy to assign a particular article or book to one particular category.

Therefore, this typology represents only one attempt of several possible ones at organising the literature.

One book, 'Euthanasia examined' by Keown (1998) brings together 18 articles on the 'ethical, clinical and legal perspectives' of euthanasia and thus cuts across the first three categories. Excluding personal and fictional accounts, the Keown book can be regarded as representative of the current state of 'expert' debate on euthanasia ('experts' denoting a category of people that are - and are widely regarded to be - knowledgeable about the different aspects of euthanasia on the basis of their professional involvement with euthanasia, as opposed to laypeople who are personally involved). The description in this chapter of the state of expert debates on euthanasia was consequently based on the material provided by the eighteen contributions to 'Euthanasia examined' and organised principally around definitions.

This chapter has established that 'euthanasia' is represented by 'experts' as a major issue of public concern, for society as a whole and doctors and patients in particular, for it is seen as first and foremost a medical issue. What exactly constitutes 'euthanasia' in practice is a matter of dispute, depending on the acceptance of certain categories and the ways of drawing the boundaries between them, as well as the conceptualisation of those boundaries as strong, weak or even non-existent. Some of those concepts and categories we will come across again in the newspaper data.

Chapter (5) – Stories about Conflict – Setting the Scene.

Introduction

The analysis presented in chapter (4) shows that people can mean different things when they say ‘euthanasia’. They might talk about the active killing of terminally or not terminally ill people, with and/or without their request. They might refer to the withholding of extraordinary or ordinary treatment or care from incompetent and/or competent people. They might include the assisting of a suicide in not necessarily physically ill people. They might argue for or against one or another. They set the boundaries around the concept of ‘euthanasia’ in different ways. This is no different in ‘expert’ than in lay discourse (although expert discourse may be more detailed and precise), which gives me a starting point for this chapter: ‘Euthanasia’ is a concept that can be employed to refer to different things. It is a matter of empirical analysis to discover the range of ideas and practices that it is being used to refer to. I proposed to conduct an analysis of stories that have appeared in British newspapers over the course of one year (November 1998 to October 1999), the articles being selected on the basis of the presence of the word ‘euthanasia’ somewhere in their text. There are 328 articles, and 41 different story-lines. Confronted with such a wealth of text, it is impossible to ‘just describe’ what the stories contain. With the view of imposing some sort of order, some analytical categories have to be devised with reference to which the stories can be ‘described’ in terms of an overall structured scheme.

‘Case stories’ and ‘other reports’

Before I explain how I arrived at the categories of that scheme, I have to make some general comments about the data. I have said that I am interested in discovering the range of ideas and practices that the word ‘euthanasia’ is used to refer to. With that goal in mind, it makes sense to divide the articles into two kinds: ‘case stories’ and ‘other

reports' ('other reports' being a residual category of every kind of story that cannot be described as a 'case story'). 'Case stories' are the stories that refer to individual cases in which 'euthanasia' is an issue; they are stories of conflict that result in police investigation or court proceedings. A hypothesis that cannot be tested in this study is that similar cases, in which the parties involved are not in conflict, never make it into the press. The existence of such cases cannot be proved here but can be assumed on the basis of the results of surveys like the one by Tate and Ward (1994) of British doctors that established that patients do make requests for euthanasia (in this survey, half of the doctors had been asked by a patient to take active steps to hasten death) and that doctors do comply with some of those requests (a third of the doctors asked had complied with a patient's request). This suggests an incidence of euthanasia much higher than would be derived from the press coverage on the topic. This has to be kept in mind in order to remember that we are dealing with a certain construction of reality, including one where events are not 'naturally' newsworthy. Rather:

'Things are newsworthy because they represent the changefulness, the unpredictability and the conflictual nature of the world. But such events cannot be allowed to remain in the limbo of the 'random' – they must be brought within the horizon of the 'meaningful'. This bringing of events within the realm of meanings means, in essence, referring unusual and unexpected events to the 'maps of meaning' which already form the basis of our cultural knowledge, into which the social world is *already* 'mapped'. The social identification, classification and contextualisation of news events in terms of these background frames of reference is the fundamental process by which the media make the world they report on intelligible to readers and viewers. This process of 'making an event intelligible' is a social process – constituted by a number of specific journalistic practices, which embody (often only implicitly) crucial assumptions about what society is and how it works' (Hall et al 1996, p.425).

On the basis of this understanding of the social construction of news, it is the 'case stories' that interest me most in this chapter. The 'case stories' as news stories are stories

as well as news. Stories are always narratives, relating a temporal sequence of events. Narrative analysis, for example Propp's work on fairytales (see Silverman 1993 and Alasuutari 1995) looks at individual stories as variants of a 'macrotale'. This 'macrotale' represents the structure in terms of the function of different characters, underlying the massive detail and complexity of the individual stories. In this chapter, I will conduct a loose version of narrative analysis, in the sense that I will look at elements of the individual stories in order to locate the differences and similarities between the stories. Thus, the 'case stories' allow me to study the variations of certain dimensions of each case in terms of their relation to the term 'euthanasia'. My residual category, all 'other reports', refers to reports of studies undertaken with respect to public or professional opinions on 'euthanasia', reports of developments in the legal arena that have a bearing on 'euthanasia' in this and other countries, stories about individuals who have something to say either in relation to the promotion or the rejection of the idea and practice of 'euthanasia', reports about soap operas, a play, a book that somehow deals with 'euthanasia', etcetera.

Main stories and minor stories

A further division between the stories can be made, which has as its only purpose to give the reader an idea of the relative importance of stories in terms of their coverage. This is the loose division of stories into 'main stories' and 'minor stories'. 'Main stories' run in all or most newspapers, sometimes over weeks or months. Apart from the news reports, they inspire other articles that comment on or discuss certain issues seen as arising from the story in more detail. 'Minor stories' have much less coverage, sometimes as little as one article in one newspaper. Some stories fall in between those two categories, so the division is not completely accurate. For my purposes, a minor story is treated in the same way as a major story. Nevertheless, for the sake of giving the reader an image of the data archive: there are 13 'case stories', of which 6 are considered 'main stories' and 7 'minor stories'. The 'other reports' altogether contain 28 stories, of which 5 can be classed as 'main stories' and 23 as 'minor stories'. This suggests that although there are numerically less 'case stories' than 'other reports', more of the 'case stories' are run in more

newspapers and over a longer period of time. Indeed, the biggest story of that year is a ‘case story’ (the Dr. Moor case), which on its own makes up almost one-sixth of the whole data archive (for a more detailed analysis of the Dr. Moor case, see Chapter (6)).

Analysis of the case stories

My analysis in this chapter concentrates on the ‘case stories’. As I said before, these are stories about conflict. 11 stories are reported court cases and two refer to police investigations. What they have in common is that they all involve the term ‘euthanasia’. Apart from that, they differ in almost every other way. For example, the majority of stories involve dead bodies, but in five cases there is no corpse. To be able to summarise the content of the stories, it is essential to identify which are the meaningful dimensions that are present in all the stories and along which the stories differ. There are five dimensions around which the similarities and differences between the stories can be said to revolve. These dimensions seem to be particularly apt – other readers may have identified others:

1. *Attributes of the receiver of the action* (terminal illness, competence, self-determination)
2. *the action* (completed, attempted or proposed; killing or withholding/withdrawing ‘treatment’ or other)
3. *the actor* (who has/is to perform the action?)
4. *the social location of the conflict* (doctor and relatives against the state, doctor against relatives and state, relatives against doctor and state and other constellations)
5. *the nature of the conflict* (for example: has s/he done the killing [killing is not right], does the action constitute killing or not [implies that, as long as it is not killing, it is right], is the killing justified or not [killing could be right])

It has to be kept in mind that the purpose of drawing up this analytic scheme is to provide entry into the data in order to describe a coherent picture of the content of a large number of texts. The questions of ‘who?’ (who is the actor? who is the receiver?) have

unambiguous answers provided in the texts, whereas other dimensions like the nature of the 'action' and the 'attributes of the receiver' are presented in ambiguous ways and sometimes as being contentious. As we have seen in chapter (4), there are disputes among experts as to the categories into which to fit a particular action. Similarly, there is no agreement over the categorisation of people and their suitability for certain action to be performed on them. These issues are also reflected in the newspaper data. My analytical scheme should make it possible to see the controversies and write about them as findings. I will start with a discussion of the 'attributes of the receiver of the action'.

The attributes of the receiver of the action

First of all, we live in a society in which, in principle, all deaths need to be accounted for. The legal classification of death is a complete classification system, meaning that all deaths fall in one or another of its categories. The main legal categories are 'natural causes', 'accidental death', 'death by misadventure', 'suicide', 'murder', 'manslaughter', and 'not known'. However, only a few of those categories fall under a criminal classification: murder and manslaughter. Murder is thus a legal and a criminal category. Murder is defined as one person killing another person intentionally. As the law stands, this includes 'euthanasia', which involves one person killing or assisting in the death of another person intentionally. Thus, 'euthanasia' is not a separate legal or criminal category under the law. To make 'euthanasia' visible as a separate category within that system, it has to be differentiated from 'murder' somehow. This conceptual work is being done by persons and organisations with an interest in making this distinction. In the UK, it is mainly the Voluntary Euthanasia Society. I will borrow their criteria of the conditions that they believe define 'voluntary euthanasia', as opposed to 'murder'. These criteria are consistent with the criteria put forward by other interested parties, including the criteria enshrined in the law in Holland, where 'euthanasia' has just been legalised (November 2000). Those criteria relate to attributes of the receiver of the action. I deliberately do not say 'patient', and will make clear why this is so later on in the discussion. The concepts I have derived from those criteria are what I will call: 'terminal illness', 'competence' and 'self-determination'. I will use those concepts as if they were

unproblematic, even though I am well aware that they are not. They are concepts defined by the same professionals who have the power to assign a person into one or the other category. 'Self-determination' is slightly different from the other two. It refers to whether the action is carried out as a result of an autonomous decision by the receiver, or a decision by the actor or other champion of the action (it is irrelevant at the moment whether that decision was made in relation to 'best interests' of the receiver or other interests of the actor/the person proposing the act). Just like 'terminal illness' and 'competence', 'self-determination' has to be seen as a fluid concept (how ill is terminally ill, how competent is competent enough, how much self-determination is real self-determination?) which becomes momentarily solid only when those how questions have been answered in relation to some putative threshold. For my purposes, it does not matter where that break-off point is. I will only look in the newspaper articles for whether the receiver of the action is said to be terminally ill or not, competent or not, and with relation to the action, self-determined or other-determined.

In order to further clarify my thinking, I will make a 'truth table'¹. This truth table starts from the definition of 'voluntary euthanasia' as having to involve the informed request (sic - not 'demand' or 'consent') of a competent, terminally ill person. The table will show that if we want to single out 'voluntary euthanasia' from murder on the basis of this definition, we will have to deal with all the other cases that are defined by the variables terminal illness, competence and self-determination.

¹ In the chapter entitled 'Logic' in his book 'Tricks of the trade' (1998), Howard Becker demonstrates the usefulness of truth tables to sociological analysis.

Truth table based on the definition of ‘voluntary euthanasia’ as involving a terminally ill, competent and self-determined person

	Terminal illness	Competence	Self-determination	Description of possible cases
1	+	+	+	Voluntary euthanasia
2	+	+	-	Involuntary euthanasia = Murder
3	+	-	-	Non-voluntary euthanasia
4	+	-	+	Euthanasia on basis of living will
5	-	+	+	Voluntary Euthanasia? for chronically ill person
6	-	+	-	Murder
7	-	-	-	(Non-voluntary) Euthanasia? for PVS, Alzheimer patient without living will
8	-	-	+	Euthanasia? for PVS, Alzheimer patient with living will

This truth table shows all the possible variations of what is conventionally called ‘murder’, as differentiated in terms of the presence or absence of the variables ‘terminal illness’, ‘competence’ and ‘self-determination’. It immediately shows the difficulties with assigning cases to the categories. Case (1) would be the case that typifies what has come to mean ‘voluntary euthanasia’. Case (5) is similarly voluntary, but can it be called ‘euthanasia’ in the absence of terminal illness? However, how is terminal illness defined? Applying a very narrow definition of someone in the terminal phase of illness (that is, the

dying process has started), puts anybody with a chronic degenerative disease, people with a prognosis of six months to live, and people with or without minor health complaints (like the old man who was tired of life and helped to die by a physician in Holland - who was not convicted of ignoring the guidelines (Frankfurter Rundschau, 1.12.2000)) into the same category. Cases (4) and (6) make use of a convention to allow formerly competent, now incompetent people to exercise self-determination: living wills that specify in advance the kind of treatment (and could specify the wish for euthanasia, but don't at present) a person anticipates he or she would want if becoming incompetent. Again everything depends of the definition of terminal illness and its opposite – somebody not terminally ill and judged not competent could be a person in a coma or PVS as well as a person with Alzheimer's disease. This typology cannot distinguish between those cases. Cases (3) and (8) refer to the treatment/killing of incompetent people, for example on the basis of their 'best interests' or for other reasons? This is being discussed both for terminally ill incompetent people and people in PVS or coma. It is not discussed in relation to mentally handicapped people, although they could fall equally into this category. Cases (2) and (7) refer to murder in its narrower sense, here defined as carried out on a competent person not wanting to be killed, the criterion of terminal illness thus becomes unimportant. It will be clear now why I did not want to talk about 'patients' as this table introduces an exhaustive classification for every action that formerly would fall into the category of murder, including not only talking about 'patients' - people with illnesses who are in a social relationship with (a) health professional(s) - but also about more or less healthy people who cannot be said to be patients.

We can see from this brief discussion that the table is only useful as a first step into the mass of data. It is one way of classifying. There could be others that could, for example, introduce more divisions rather than the simple presence or absence of terminal illness. As it has been drawn up for my particular analytic purposes, it does not matter. Newspapers talk about the presence or absence of terminal illness (or conflict over the assignment of the person to one or the other category), and that is what I will be able to capture with this classification.

Killing or not killing

The table was drawn up to differentiate between different cases of murder, that is one person deliberately killing another person. As I have said before, there are different opinions about what constitutes 'killing'. Some constellations of the presence or absence of the three factors refer to situations in which it is possible to perform actions that can be called something other than 'killing' that result in or have an influence on a person's death. In less abstract terms: if somebody is kept alive by a machine, that machine can be turned off and the patient dies. This event is conceptualised by different people as constituting an act of killing, or an act of withdrawing treatment constituting something other than killing, or even an omission which has nothing to do with the death (death being conceived as the direct result of the underlying illness). I suggest that the above table, even though it has been drawn up with respect to murder, is still useful in those cases. For my purposes I want to extend it to apply to those cases. This of course complicates things further. To recapitulate: the above table describes all the categories possible, differentiated with respect to my three variables: 'terminal illness', 'competence' and 'self-determination'. All of them together describe the totality of cases that otherwise come under the legal and criminal category of murder. Extending that table to cases where the act of 'killing' is contentious, means moving into a 'grey area', where from a legal and criminal perspective it is not certain any more whether we are talking about murder or not.

To repeat: I will look at the 13 identified cases with the aim of finding out about the attributes of the receiver of the action, the action itself, the actor, the social location of the conflict and the nature of that conflict.

The Case Stories

[1] Dr. Kevorkian – an American court case

In November 1998, Dr. Kevorkian is charged with murder after a video tape had been shown on a TV documentary program in the USA where he is seen injecting a terminally-ill person who subsequently dies. He claims that his intention in making the tape public was to challenge the authorities to finally clarify the law on assisted suicide – he had been involved in assisted suicide cases before and was taken to court for it, yet he was never sent to prison, nor did the cases affect any change in the law. He stands trial in December, appears in court and is convicted of murder in March 1999. In April he is imprisoned for 10 to 25 years. In June, the film ‘Appointment with Dr. Death’ about Dr. Kevorkian is shown on British television.

1. *attributes of the receiver of the action*: terminally ill with Lou Gehrig’s disease (in Britain usually called ALS, or Amyotrophic Lateral Sclerosis), signed forms consenting to assisted death (competent and self-determined)
2. *the action*: completed, injection with a fatal dose of potassium chloride
3. *the actor*: Dr. Kevorkian, a known euthanasia advocate
4. *the social location of conflict*: doctor (with relatives) against the state
5. *the nature of the conflict*: as there is no doubt there was a killing, the court has to decide whether he intended to murder Mr. Youk – the media ask: is Kevorkian an ‘angel of mercy’ or the ‘instrument of murder’ (Western Morning News, 15 June 1999), was he right or wrong in killing?

In terms of the attributes of the receiver, we have a case (1) (see Truth Table) in terms of my earlier scheme; the man was killed, that means it could be called a case of voluntary euthanasia. It was performed by a doctor. The case centres around the weirdness of the man – the *perverted doctor*:

‘... he is the kind of man who gives killing people a bad name.’ (Independent, 29 Nov 1998). ‘An American jury has refused to accept the eccentric Dr. Jack Kevorkian as the

acceptable face of euthanasia' (The Observer, 28 March 1999) – these striking quotes imply that not euthanasia itself is bad, but this particular advocate of it.

[2] 'Backdoor euthanasia' – a police investigation

In January 1999, an investigation by police and health authorities into about fifty cases of so-called 'backdoor euthanasia' in hospitals around Britain is reported. Junior nurses and relatives have been raising the alarm, alleging that doctors and senior nurses have been withdrawing food and water from patients who are claimed not to have been terminally ill. In September, the same investigation makes it into the press again, reporting that hospital staff may indeed be facing serious allegations.

1. *attributes of the receivers of the action*: mainly elderly, minor complaints not terminally ill, not self-determined, how competent?
2. *The action*: completed, withdrawal of nutrition and hydration
3. *The actors*: hospital doctors, senior nurses
4. *The social location of the conflict*: doctors and senior nurses against junior nurses and relatives
5. *The nature of the conflict*: good medical practice, serious professional misconduct or murder?

The papers write that the receivers were not terminally ill and death was not self-determined, but it is not made clear whether the victims were competent, or made incompetent only by the withholding of nutrition and hydration. We have a case (6) or case (7) (see Truth Table), that is straightforward murder (if competent). On the other hand, it could be euthanasia of a demented person, which falls outside the usually discussed cases of 'euthanasia' involving terminal illness ((1) to (4)). Is withholding food and nutrition murder, or is it good medical practice because to force-feed would amount to torture? Are we dealing with 'backdoor euthanasia' or 'giving nature a helping hand' (Times, 18 January 1999)?

[3] The attempted killing of a man by his wife

In February 1999, a female member of the Voluntary Euthanasia Society is granted bail after admitting to having attempted to murder her husband. She gave him pills and tried to smother him with a pillow, when he fell out of bed. She was afraid he had hurt himself in the fall and called the ambulance men, to whom she told everything. Her husband has been ill for years with a form of dementia and is also a member of the VES. In March she appears in court and is sentenced to two years probation.

1. *attributes of the receiver of the action*: not terminally ill, not competent due to severe dementia, he has made a living will so is he self-determined or not?
2. *The action*: attempted, overdose of pills and smothering with a pillow
3. *The actor*: Vicky Wood, the wife, a member of the VES
4. *The social location of the conflict*: relative against the state
5. *The nature of the conflict*: in court: is she guilty of murder or manslaughter? Outside of court: did she do right or wrong?

We have a case (7) or (8), depending on whether the patient is considered to be self-determined. Because of the absence of terminal illness, the case falls outside the usually discussed euthanasia cases involving terminal illness, (1) to (4). It is suggested it would have been better to have kept quiet about what she did: 'Had Mrs. Wood not been so 'damagingly honest', no one would have known of the murder attempt on her husband of 21 years, the court was told' (Daily Mail, 30 March 1999).

[4] Dr. Tylor – a case of 'backdoor euthanasia'?

March 1999 - The hospital doctor, Dr. Tylor, is standing trial for ordering nursing staff to let a stroke victim starve to death.

1. *attributes of the receiver of the action*: not terminally ill (but repeated strokes, Parkinson's, dementia), not self-determined, how competent (she communicated by squeezing the nurse's hand)?
2. *The action*: completed, withholding nutrition and hydration
3. *The actor*: Dr. Tylor, hospital doctor
4. *The social location of the conflict*: nurse against doctor and relatives
5. *The nature of the conflict*: good medical practice, professional misconduct or murder?

This case can be seen as one instance of the general allegations of 'backdoor euthanasia' in British hospitals. However in this case, the relatives were on the doctor's side, indeed he holds that they approached him and suggested that he should do something. It is the nurse who claims Dr. Tylor 'suggested euthanasia' (Times, 17 March 1999). Again we have a case (6) or (7), hinging on the judgement of competence.

[5] The biggest case – Dr. Moor and the 'double effect'

In April 1999, Dr. Moor is arrested for the alleged murder of a cancer patient and tried in court after publicly airing his views on euthanasia and claiming to have helped terminally ill people to die. In May, the jury unanimously accepts the defense of the double effect and decides that the fact that he has injected the patient with diamorphine does not mean that he is guilty of murder. He is freed.

1. *attributes of the receiver*: terminally ill with cancer, not self-determined, not competent (could only scream)
2. *the action*: completed, injection (overdose?) of diamorphine
3. *the actor*: Dr Moor, GP
4. *the social location of the conflict*: doctor (with relatives) against the state
5. *the nature of the conflict*: in court: pain relief or intention to kill? Outside of court: was he right in giving an overdose, if he did so, or wrong?

This would be a case (3), or non-voluntary euthanasia, if the dose of diamorphine was so high to only have been intended to kill the patient. Because of problems with the toxicological evidence, it could never be proved whether there has been an overdose or not. The defense rested on the idea that pain relief with morphine is always risky and can lead to slightly premature death, however as long as the intention is to relieve pain and not to kill, this is acceptable (the double effect). The jury made their decision on the assumption that Dr. Moor's intention was to relieve pain, not to kill.

Most papers quote the judge describing Dr. Moor's statement in support of euthanasia as 'silly remarks to the press' (for example Independent, 12 May 1999), suggesting that he brought the trial onto himself, and as in the case of Vicky Wood, suggesting he ought to have kept quiet.

(See Chapter (6) for more detail on the Dr Moor case).

[6] Rescuing her son

Also in April 1999, a mother claims that a hospital has acted illegally when doctors decided – against her wishes and without going to court – to give her 12-year old severely disabled, and, according to the doctors, dying, son the painkiller diamorphine that is known to hasten death. There had been a physical fight between relatives and doctors at the hospital when the relatives tried to bring the boy back to life. The boy lives. She lost her battle in High Court.

1. *attributes of the receiver of the action*: profoundly disabled, terminally ill? Not competent and not self-determined
2. *the action*: attempted, giving of painkiller diamorphine
3. *the actor*: hospital doctors
4. *the social location of the conflict*: relatives against doctors
5. *the nature of the conflict*: did the doctors act illegally? Good medical practice or serious professional misconduct?

We have here a case (3) – non-voluntary euthanasia, or a case (7), depending on whether the boy is considered to be terminally ill. The fact that six months later he is still alive suggests that he was not terminally ill, at least not in the stage of dying. Here, the relatives have a strong interest in keeping the boy alive, while the doctors describe the actions of the relatives to resuscitate as torture. ‘They administered the strong painkiller diamorphine to ease his suffering and allow him to die a peaceful and dignified death’, whereas ‘Mrs. Glass, 38, believed her son’s life was worth saving and with the other relatives kept him alive by refusing to let him slip into unconsciousness’ (Daily Mail, 23 April 1999).

[7] Austrian Nazi doctor on trial for euthanasia killings

April 1999 – in Austria, a doctor is standing trial accused of involvement in the Nazi euthanasia murders of disabled children. His post-war reputation had been built on research conducted largely after the war (and until recently) on the preserved brains of the children killed in his clinic.

1. *attributes of the receivers of the action*: mentally and physically disabled children, not terminally ill, not self-determined, how competent?
2. *The action*: completed, killing by poison
3. *The actor*: Dr. Gross
4. *The social location of the conflict*: doctor (and Nazi state) against today’s state
5. *The nature of the conflict*: agreement in court and outside: murder

The victims were ‘deaf, dumb or blind, suffered from Down’s syndrome or epilepsy, had a cleft palate or harelip, or were simply ‘problem children’ (Sunday Times, 18 April 1999). From today’s point of view, those children were probably competent. Therefore, we have a straightforward case (6), or murder. However, if there were children so mentally disabled to not be considered competent, we might have cases of (7), in terms of my scheme, similar, for example, to euthanasia for an Alzheimer patient. This possibility is however ignored, probably to strengthen the distance between today and Nazi times.

Dr. Gross is quoted as saying: ‘they were children so mentally backward that they were physically paralysed. You couldn’t expect them to function in society. (Sunday Times, 18 April 1999). The quote exemplifies this distance: it is suggested that today, our focus is supposedly solely on the individual and his or her best interests, whereas Nazi Germany looked at the individual from the perspective of the interests of society (again, supposedly). The effect is to suggest that everything is so different today that things like those killings could never happen in today’s world. The mother/son case, also involving a disabled child, could be seen as a possible challenge to that belief.

[8] The French nurse

In June 1999, a French nurse admitting to having killed terminally ill patients is charged with murder in a case that has sparked fierce nationwide debate on euthanasia in France.

1. *attributes of the receiver of the action*: many terminally ill patients, we know nothing of their competence or self-determination
2. *the action*: completed, morphine injections
3. *the actor*: hospital nurse
4. *the social location of the conflict*: nurse against state (and apparently some relatives)
5. *the nature of the conflict*: in court: did she kill or not? Outside of court: is she a ‘serial killer’ or a ‘Madonna of euthanasia’ (Times, 16 June 1999)?

We know very little about these cases, only that they involve terminally ill people. They might be any cases from (1) to (4), voluntary euthanasia, involuntary euthanasia, non-voluntary euthanasia or even euthanasia on the basis of a living will (if we counted an understanding between nurse and patient - before the latter had become incompetent – as equivalent to a living will). However, it is said that some relatives are suing, which suggests the most likely scenario of non-voluntary euthanasia of terminally ill, incompetent and not self-determined patients – case (3).

[9] Persistent Vegetative State patient

In July 1999, it is reported that a Scottish Court of Session judge will be asked to give doctors permission to stop feeding a woman who has suffered brain damage during the birth of her child three years before and has been in PVS since.

1. *attributes of the receiver of the action*: not terminally ill but in persistent vegetative state, therefore incompetent and not self-determined
2. *the action*: proposed, withdrawal of nutrition and hydration
3. *the actor*: doctors (according to wishes of the family)
4. *the social location of the conflict*: relatives (with doctors) apply at the state for examination of whether any state interest would be violated by letting the woman die
5. *the nature of the conflict*: is the withdrawal of feeding illegal or not? It is not asked whether the action would constitute killing or not, only whether the action would be in line with the law

No mention is made of a known wish of the patient. This action is proposed on the basis of the wishes of the family who 'want her to be allowed to die with dignity' (The Herald, 5 July 1999), therefore we are dealing with a case (7). It is said that the Lord Advocate 'had earlier ruled that doctors would not be prosecuted if they stopped treating patients in Persistent Vegetative State' (ibid.).

[10] Coma woman

August 1999 – A husband has launched a legal battle to allow his wife to die. She has been in a coma for six months after a stroke at the age of 42. She has some brain activity which puts her outside of the legal precedent set by the 1992 Bland case (PVS), in which the court ruled that the withdrawal of tube-feeding would not be illegal.

1. *attributes of the receiver of the action*: not terminally ill, in coma after stroke, incompetent, self-determined?

2. *The action*: withdrawal of nutrition and hydration
3. *The actors*: doctors (according to wishes of the family/the patient herself?)
4. *The social location of the conflict*: relatives (husband) (with doctors) apply to the state (see PVS case)
5. *The nature of the conflict*: is the withdrawal of fluids illegal or not? Again it is not asked whether it constitutes killing or not.

The family says that the patient had mentioned in the past that she wouldn't want to go on living if in a coma. That would make this a case (8) – if the statement is accepted as a living will. If not, it is a case (7). There is some apparent confusion about whose wishes we are actually dealing with, exemplified in the quote from the mother: "Seeing Lorraine like this has made me even more sure that voluntary euthanasia should be legalised", she said. 'If I could give her an injection now, I would'" (Daily Mail, 26 August 1999). It does not seem to occur to her that what she proposes to do would be non-voluntary, not voluntary euthanasia. I will come back to this. It is also said that 'doctors say if he [the husband] wins it would be a significant step on the road to legalised euthanasia' (ibid.), making no qualification as to what kind of euthanasia.

[11] The grandson

Also in August 1999, a grandson who had switched off his grandmother's life-support machine to end her suffering is not convicted for attempted murder. He had barricaded himself into the hospital room with her to achieve this, fending off doctors and nurses who eventually broke the barricade down and carried out emergency treatment on the grandmother. The grandmother who has heart disease is alive.

1. *attributes of the receiver of the action*: assumed to be incompetent, not self-determined, terminally ill? Severely ill with heart disease
2. *the action*: attempted, switch off life-support
3. *the actor*: Mr. Karapetian, grandson
4. *the social location of the conflict*: grandson against doctors and state

5. *the nature of the conflict*: in court: was it attempted murder? Outside court: murder or mercy? Did he do right or wrong?

The grandson was under the impression that his grandmother was dying and that keeping her alive on life-support was torture. Mr. Karapetian is quoted as saying: 'I felt that everyone was torturing my grandmother for their own selfish reasons. She was being made to suffer by not being allowed a natural and peaceful death' (Evening Standard, 10 August 1999). That would make this a case (3), of non-voluntary euthanasia, or a case (7) if she were not considered terminally ill.

What the grandson did is called a 'euthanasia attempt' (Evening Standard, 20 August 1999), and there is no qualification of whether switching off life-support is any different from killing.

[12] Death of a woman with a leg ulcer – another example of 'backdoor euthanasia'?

September 1999– the bereaved daughter of a woman admitted to hospital with a leg ulcer wants her body to be exhumed after a 'leading expert' (Dr. Irwin, the Vice-chairman of the VES) concluded that she was the victim of involuntary euthanasia.

1. *attributes of the receiver of the action*: elderly lady with leg ulcer, not terminally ill, probably competent (until starved), not self-determined
2. *the action*: completed, according to medical notes: DNR and diamorphine
3. *the actor*: hospital (doctors, nurses?)
4. *the social location of the conflict*: relative against hospital
5. *the nature of the conflict*: involuntary euthanasia = murder, or good medical practice?

It is interesting that the 'expert' is a leading advocate for voluntary euthanasia – in this case he is revealed as a fierce opponent of involuntary euthanasia. Dr. Irwin is quoted as saying: 'I believe that involuntary euthanasia was performed on Mrs. Gibbings.

Involuntary euthanasia can be defined as ending someone's life who could consent but does not. Such an action is indistinguishable from criminal homicide and the claim that

the motive for killing is in ‘the best interest’ of the patient is irrelevant’ (Times, 30 September 1999). We have a case (6), or straightforward case of murder.

[13] Dr. Shipman, the mass murderer

In October 1999, Dr. Shipman is brought before court for having murdered 15 women who were not terminally ill by giving them lethal injections.

1. *attributes of the receivers of the action*: not terminally ill, not self-determined, competent
2. *the action*: completed, lethal injections of mophine or diamorphine
3. *the actor*: Dr. Shipman, GP
4. *the social location of the conflict*: doctor against relatives and state
5. *the nature of the conflict*: agreement in court and outside: murder of the most horrendous kind, by a trusted doctor

This is a straight forward case (6) of competent people being killed against their will – unambiguously murder. The only reason why it appears under the heading of euthanasia is that it has been performed by a doctor. He is another instance of the *perverted doctor*, who ‘enjoyed killing’ – ‘he was exercising the ultimate power of controlling life and death and repeated it so often he must have found the drama of taking life to his taste’ (Guardian, 12 October 1999). Because a doctor is involved, the papers feel they must make it clear that ‘there is not question in this case of euthanasia or mercy killing. None of the deceased were terminally ill’ (Daily Record, 12 Oct 1999). This quote links euthanasia to terminal illness rather than, for example, the question of whether the deceased wanted to be killed.

Similarities and Differences

In the following I will attempt to bring out the similarities and differences that make up the 13 cases - each one with its own wealth of individual characteristics - based on the short descriptions above. I will structure my summary along the five dimensions - the attributes of the receiver of the action, the action, the actor, the social location of conflict and the nature of that conflict.

1. Attributes of the receiver of the action

The cases differ in one obvious way in terms of the receiver: in some, the receiver is one individual whose circumstances are well known, in others several or many people are involved on the receiving end, and here we are much less clear what their individual and common characteristics are. Concentrating for the moment on the attributes of the receiver, regardless of exactly what form the action with regard to him, her or them takes, shows us that only in half the cases does the receiver fall unambiguously into one category in my scheme. This is the case, for example, in the Dr. Kevorkian [1] (terminally ill, competent, self-determined) or the Dr. Moor case [5] (terminally ill, incompetent, not self-determined). In these cases, the conflict centres around the nature of the action. Does their action constitute murder? In the other half of the cases, the newspapers are not clear on the issues, or leave so much room for interpretation that the receivers could be consigned to two categories. In those cases (for example the case of Vicky Wood [3], the mother/son case [6], or 'backdoor euthanasia' [2]) it seems that the nature of the conflict is even more complex, as the question is not only to the nature of the action, but in addition revolves around disagreements between several parties as to the interpretation of the attributes of the receiver. In the case of Vicky [3], it hinges on self-determination: her husband had told her many times that he wanted her to help him die, before he became incompetent – does that mean her action was (via the living will solution) in some way self-determined by him? In the mother/son case [6], the disagreement is over whether the son was dying, or terminally ill. The doctors thought so, the relatives didn't. In the cases of 'backdoor euthanasia' [2], we do not know about the

competence of the receivers involved. The interpretation of the actions of the doctors would hinge to some extent on the question of competence. However, as I have already said in the introductory part to this chapter, competence hinges, just like the concepts of terminal illness and self-determination, on its definition. There are liminal cases where the definitions appear unambiguous – where a person is without the signs of any known illness, he or she has to be considered healthy; where the person decides to die and carries out the action him- or herself, there is no mistaking; where the person is conscious and able to hold whatever is considered a rational conversation, the person is evidently competent. On the other hand, where a person had entered the dying phase, this is visually obvious; or where a person is in a deep coma or what is called the Persistent Vegetative State, he or she is unable to enter into any kind of communication and must thus be considered incompetent and incapable of self-determination. However, with the coma [10] and PVS [9] cases, there is the possibility of change over time (and person can surface from both conditions to a differing extent). The vast majority of people would fall somewhere along a continuum between those extremes. Discounting for a moment the common cold and other minor ailments, with reference to more severe illnesses there are differences in how well their prognosis is known, how accurate the diagnosis and prognosis is in the individual patient, and to what extent they are considered to be chronic or degenerative conditions.

What are the conditions we are dealing with in the 13 cases? There are instances of Lou Gehrig's disease (or ALS), a progressive and eventually fatal muscle disease; elderly people with minor complaints; one with a leg ulcer; people with dementia; strokes; cancer; disabled children; PVS; coma; heart disease. Three are said to be terminally ill, two maybe and eight not. Only one of those, the person with Lou Gehrig's disease (or ALS) [1], complies roughly to the type of patient that, according to the Voluntary Euthanasia Society, should be offered the possibility of voluntary euthanasia, being competent and self-determined. He is said to be 'terminally ill', obviously not immediately dying but apparently ill enough to be expected to die of his illness very soon. Dr. Moor's cancer patient [5] comes close, he is terminally ill but apparently incompetent and not self-determined. In fact, almost all the other cases involve people who are not self-determined – in the extreme cases of coma [10] and PVS [9], the

patients are deeply unconscious as well as incompetent. The rest of the patients appear all to have been judged incompetent – even if there is conflict about that in some cases – including the disturbing case of the Austrian doctor [7], where we do not know how competent we would have judged his victims to be in today's terms, knowing only that some of them were mentally ill. It is possible that in the cases of 'backdoor euthanasia', the medical practice of the health professionals involved (starvation and dehydration) only made the patients incompetent. Only in the case of Dr. Shipman [13], the judgement is unanimous that his patients were competent, which makes him a straightforward murderer.

Considering that the majority of receivers are dead, and before that were judged incompetent, it is not surprising to find that they hardly play a role in the newspaper articles. They are all but absent. The 'stars' of the articles are the people who are brought before court, in the case of Drs. Kevorkian [1], Moor [5] or Shipman [13] arousing admiration or grisly fascination. Here are some of the headlines:

Dr. Moor: 'Murder charge doctor could have killed 300, court told' (Birmingham Post, 17 April 1999)

Dr. Shipman: 'Doctor killed 15 old ladies for fun. Court hears how GP murdered patients because 'he enjoyed it'' (Daily Record, 12 April 1999)

Dr. Kevorkian: 'Doctor condemns 'cruel' jury's verdict of murder. The conviction of 'Dr Death' prompts calls for euthanasia review' (Observer, 28 March 1999)

Dr. Moor again: 'Tightrope all doctors walk' – GP cleared of murdering patient tells of risks in caring for dying' (Journal, 12 May 1999)

In the cases of family fighting to let their relative die or live, there is a sympathetic tone in the articles, as the following quote from an article on the coma case [10], where a husband wants his wife to be allowed to die, exemplifies:

‘I’m in a state of limbo. I can’t go forward in my personal life as Lorraine would want me to’ [...] He says he does not believe there is any hope of her recovering. Yet he cannot grieve and his wife cannot be at peace’ (Daily Mail, 26 August 1999)

Here, sympathy centres around the relative (as the subject), the patient herself figures generally as the object of the subject’s actions and emotions.

I suggested in the beginning of the chapter that it is probable that the stories involving euthanasia that get into the papers are stories of conflict. From the above it seems that most conflict arises when people are not in a position any more to make up their own minds, others decide to do it for them, and then several others clash in their ideas as to what should be done. Cases like the Dr. Moor case [5], the Dr. Kevorkian case [1] and the case of Vicky Wood [3] are all exceptional in their own way. The comments in the press regarding Dr. Moor [5] and Vicky [3] that suggest that they would have done better to have kept quiet about what they did makes one wonder how often people do keep quiet. Dr. Kevorkian equally got into the news because instead of just doing what he did, he had to talk about it publicly (having further motives apart from helping the man to die in itself). In those three cases there was agreement between the people immediately involved. It became a problem only when it became known to the state, which considered its interests (potentially) violated.

2. The action

In 11 cases, the action was completed. In three of those, the receivers survived (the mother/son [6], the grandson case [11] and the Vicky case [3]), in nine cases the receiver/s are dead. In the remaining two cases, the action is proposed. In the cases of a coma [10] and a PVS [9] patient (both women), the relatives apply to court to allow the attending doctors to discontinue nutrition and hydration to allow the patients to die. Where the action has already happened, it consisted in the giving of morphine or diamorphine (five times, one survivor), the injection with another poison (twice, both dead), the withdrawal of nutrition and hydration (in two cases), switching off of life-

support machine (once, survived) and giving pills and smothering with a pillow (once, survived).

Giving morphine, injecting a poison like potassium chloride and the withdrawal of nutrition and hydration were all done by doctors. The switching off of life-support and the pills and pillow were done by relatives. Morphine or diamorphine are involved in very different scenarios. The most important one is the Dr. Moor case [5]. His whole defense rested on the idea that the pain killer diamorphine is essential for the control of pain in terminally ill people, but can also hasten their death (the double effect). Because there was no way to prove how much diamorphine he had given, it was assumed and accepted by the jury that he had given no overdose but a dose just high enough to serve his intention of pain relief. At the same time the dose was judged high enough to have hastened death, which however was considered not to be his intention and therefore not seen as an offense. But Dr. Shipman [13] had also given morphine and diamorphine, and there was no question that he had killed with overdoses of those substances. The French nurse [8] used morphine; the medical notes of the woman with a leg ulcer [12] read that she was given a dose of diamorphine suspected to be high enough to kill somebody who was not on morphine before; and the disabled son who was rescued by his relatives [6] was given diamorphine to allow him a peaceful death. Hospice doctors (see for example Twycross in Keown 1998) hold that morphine is essential in terminal pain relief but that there is a difference between a dose that relieves pain and one that kills, and that they know it. Also, they argue that there is a difference in how much morphine a body used to it can support and one who gets a one-off injection. Because morphine is used in pain relief, it is accessible to doctors and giving it is not immediately suspicious, but rather what doctors normally do. It is very difficult to judge what has happened when there is a health professional giving morphine and a dead body: all hinges on the intention of the doctor or nurse, but also on their knowledge of pain control and the correct dosage. In the mother/son case [6] for example, the son is still alive six months after being given diamorphine to allow him a peaceful death. If he had died, quite obviously it would have been the diamorphine that killed him. We do not know whether that result would have been down to the intention or the ignorance of the doctors involved.

The injection with a poison like potassium chloride is much less ambiguous. Potassium chloride can only be given with the intention to kill. It does not have any healing properties. Dr. Kevorkian [1] wanted to help somebody to die. He killed him with an injection of poison. He wanted that to be clear, and he made a point of saying that. The Austrian doctor [7] who allegedly poisoned disabled children fifty years ago had no reason to hide the fact that he killed in the political and social context of Nazi ideology.

The withdrawal of nutrition and hydration is, as I said, something that doctors do. The removal of nutrition and hydration ultimately leads to death. That would constitute killing. However, dying people often refrain from eating and drinking, since this can come naturally. As long as their mouths are kept moist, they do not experience any discomfort. Sometimes, to keep a person, who is already dying, alive by giving them nutrition can be considered to be bad medical practice (see for example Dunlop et al (1995), or Ellersham et al (1995)). Therefore, to stop giving nutrition and hydration is not necessarily killing. But it could be – again it hinges on the intention and the knowledge of the doctor.

‘Nutrition’ and ‘hydration’ sounds different from ‘food’ and ‘drink’. Food and drink is emotionally charged, food and drink are part of the basic care human beings give to and expect from each other. Nutrition and hydration – tube-feeding – can be conceptualised as medical treatment that can be withdrawn. In the newspaper articles, this distinction between food/drink and nutrition/hydration is not quite as straightforward. The words used in the PVS case [9]: ‘permission to stop feeding’ (Herald, 5 July 1999), and in the coma case [10]: ‘to withhold fluids’ (Daily Mail, 26 April 1999), might appear to be closer to food/drink than to nutrition/hydration. Nevertheless, in both cases this is presented as a sensible option (see below). In other places, the usage of words linked to food/drink more explicitly serve the purpose of appealing to the emotions, like in the Times article from the 6 January 1999 on ‘backdoor euthanasia’ [2], where it is said in relation to patients that ‘doctors [...] left them to die from thirst’. Also, consider the following quote:

‘Gillian Craig, a retired consultant geriatrician from Northampton, has told the Royal College of Physicians that *water* and *food* are basic human needs that should not be

regarded as treatment that a doctor may give or withhold. ‘Sadly there are times when sedation without *hydration* seems tantamount to euthanasia. This strengthens the hand of those who are pressing to legalise physician-assisted suicide. Good palliative medicine is a major defense against euthanasia, but please heed my warning. Sedation without *hydration* has enormous potential for misuse. I would like to see this regime consigned to the dustbin of history. Attention to *hydration* is not merely an option, it should be a basic part of good medicine’ (Times, 6 January 1999 – my italics).

Here, the words ‘food’ and ‘water’ perform their emotional task, whereas the use of the word ‘hydration’ is employed by the doctor/expert, who is quoted as supporting the position expressed previously by using the words ‘food and water’. Thus, the word ‘hydration’ does not automatically go with the view that it is medical treatment that can be withdrawn. Rather, the use of the technical term ‘hydration’, when used by an ‘expert’, lends authority to a particular position, whatever that position is, as well as the person uttering it.

In the following quote, another ‘expert’ is quoted using technical terms:

‘Michael Wilks, chairman of the BMA’s ethics committee, said: ‘The case is a very important reminder of how we need guidelines for doctors on these very difficult clinical issues. In previous advice we have said that *oral nutrition and hydration* are part of basic care rather than treatment and should never be withdrawn. That is, to us, fundamental’. Guidelines on the withdrawal of *artificial hydration and nutrition* through intravenous drips are expected to offer greater safeguards to patients and doctors’ (Times, 26 March 1999 – my italics).

‘Oral nutrition and hydration’ is eating and drinking, ‘artificial nutrition and hydration’ refers to tube-feeding. This shows that not only can artificial nutrition and hydration (tube-feeding) be called ‘food and drink’; in the words of an expert, the general activity of eating and drinking can become ‘oral nutrition and hydration’. This leads to opaqueness in what exactly is being communicated and can only have the function of

stressing the authority of the ‘expert’, whether he or she argues the case in favour or against (as we have seen above) the withdrawal of tube-feeding.

In the case of Dr. Tylor [4], the patient is said to have actually died from starvation rather than from her illness, judging from the body that looked emaciated: ‘A doctor who ordered nursing staff to let an 85-year-old stroke victim starve to death [...] She weighed just 3st12lb and, according to one staff member, looked like a concentration camp victim’ (Daily Mail, 27 March 1999) – ‘[...] looking like a victim of Belsen’ (Times, 26 March 1999). That could hardly be called good medical practice.

Giving morphine and withdrawing nutrition and hydration are things doctors do in their normal medical practice. When there arises conflict about their practice, it has to be decided whether what they did was good medical practice, bad medical practice/professional misconduct, or murder. The question is: did they do it, but also: what is it they did? And should whatever they did be considered to be right or wrong? In five cases, killing is uncontentious. It is generally accepted that Dr. Kevorkian [1], Dr. Shipman [13], the Austrian doctor [7], Vicky [3] and the grandson [11] intended to kill. Two of those cases are constructed as horrendous (the murderers Shipman [13] and the Austrian doctor [7]), whereas the three cases that involve mercy (Kevorkian [1], Vicky [3] and the grandson [11]) are ambiguous. In the other cases it is not so clear whether the action is or should be seen as a deliberate killing – mainly because the intention of the actors is not (yet) known, but also because of the question of the difference between good medical practice that could have death as a side-effect as opposed to intentional killing. In the two cases where relatives apply to the state to discontinue giving nutrition and hydration to patients in PVS [9] and in a coma [10], there is hardly any sense in the newspaper articles at all that this could constitute killing. Indeed, the article in the Herald from the 5 July 1999 on the PVS case [9] even makes only one single reference to dying, in its headline: ‘Court bid for brain-damaged woman to ‘die with dignity’’. The rest of the article talks about ‘permission to stop feeding’ and ‘the action’ – no more reference to dying, let alone killing. Similarly, the Daily Mail article (26 August 1999) on the coma case [10] talks about ‘allow[ing] to die’, never kill.

3. The actor

In the majority of cases (nine), the actors are health professionals – doctors or nurses. In most cases the individuals involved are well known, in others, like the ‘backdoor euthanasia’ cases [2], an institution, the hospital, is construed to be acting, in the form of some of its doctors and nurses. Adding the two cases where relatives apply in conjunction with doctors to be allowed to discontinue nutrition and hydration, there are eleven cases involving health professionals. In half of those cases, the relatives are the driving force, or with or behind the doctor, in the other half, doctors act or have acted against the relatives’ wishes. In only two cases, the actors are relatives – one at home, involving no health professionals until the arrival of the ambulance men, the other taking place in the institutional space of the hospital.

The images of the doctor actors in the press are ranging from deep sympathy to deep contempt: the celebration of the doctor acting with the best of intentions in a hazardous world; or the utter revulsion at what I call the *perverted doctor*, a doctor who violates the trust that is put into him as a doctor and who acts just like doctors should never, ever act, violating the code of ethics of the profession. Both are played out in the Dr. Moor case [5], with the press at first concentrating on the 300 deaths that he might have effected over the course of his career, based on comments by himself and some calculations by the press, playing on the mass murderer theme – until he became converted into the hero figure, doing the right thing – giving pain relief, which unfortunately has its side effects, outside the control of the doctor – it might hasten death (see headlines above). In the case of Dr. Shipman [13], there are no mediating circumstances, he is the perverted doctor par excellence, killing as he allegedly did for power and his own pleasure. The Austrian doctor [7] is the perverse doctor set in another time and place, safely distanced from today’s world by explaining his actions in terms of his time and circumstances, reassuring us that our world is not like that; but at the same time he stands as a warning to what is possible, and has actually happened.

Dr. Kevorkian [1] is the perverted doctor of a slightly different kind. Whereas the doctors I have just dealt with are all accepted by their colleagues and others to be doctors, Dr. Kevorkian is seen as so perverted in his whole person that there are actually attempts

to deny his status as a doctor. There are reports about his fall-out with the American medical profession (see for example the Sunday Telegraph, 21 March 1999), that he does not actually hold a licence to practice medicine anywhere in the United States (Independent, 29 November 1998) but he is denying that, holding that he is a medical doctor and that he acts out of his duty as a medical doctor. His fall-out with the American medical profession is reported to be based on his 'strange' fascination with death, among other things Kevorkian is reported to propose 'for death-row prisoners to commit suicide and for their organs to be removed in the minutes while they slipped from life into death' (The Scotsman, 17 April 1999). In one word, he is regarded to be so 'odd' (ibid.) and removed from 'normal' ideas of 'normal' medical doctors that they simply cannot tolerate him within their ranks. This boundary between what is 'strange' and what is 'normal' within medical practice is of course only determined by what medical practitioners do in their general practice and accept as 'normal medical practice', which in America can include without too many problems the fact that medical practitioners attend at executions. Starting from that fact, Dr. Kevorkian's idea does not necessarily seem very irrational. A medical profession which sees a radical difference between the two practices can only maintain that boundary by expelling Kevorkian from their ranks - thereby discrediting his ideas - hardly by rational arguments. Dr. Kevorkian's strange fascination with death is echoed in reports on the French nurse [8], quoting a 'psychiatric report which said the nurse had a 'morbid fascination' with death and disease' (Times, 16 June 1999). Again, deviations from socially held ideas about what is normal in relation to death and emotions are put forward as explanations for practices that themselves are seen as deviations from the norm. All this suggests that there are deeply engrained ideas about what constitutes normal behaviour in relation to death, and especially so by doctors.

4. The social location of the conflict

The social location of the conflict refers to the protagonists on the case stories among whom conflict arises, and is therefore quickly summarised (answering a straightforward 'who'-question). We have already seen above where conflict arises: it arises either over

the nature of the action, or over the attributes of the receiver and the relevance of those with regard to the action.

There are almost as many different constellations of the social location of conflict as there are cases: doctor (with relatives) against the state, doctors and senior nurses against junior nurses and relatives, relatives against the state, relatives against doctors, doctors and relatives against the state, doctor (and Nazi state) against today's state, nurse against relatives and state, relatives (with doctor) against the state, relatives against doctors and state, etc. The state is present in two ways: once taken to court, the state functions as an arbiter between different interested parties. When an interest of the state (the protection of the life of its citizens) is violated, the state becomes an interested party itself. Again we can see that health professionals are involved in most cases. The main lines of conflict are between health professionals and relatives, between health professionals themselves, between health professionals and the state and between relatives and the state.

5. The nature of the conflict

The nature of the conflict has already partly been discussed in some of the sections above. In court, the conflict revolves around whether something illegal has occurred. Outside court, questions are asked (represented in the articles as quotes from interested parties or arguments made directly by the journalist author of the articles) whether what the accused is alleged or found to have done should actually be illegal. In several cases, where we know the result of the court cases, the courts show leniency in their sentencing, reflecting discussions going on outside court as to the rightness of the action (for example in the case of Vicky Wood [3], or even Dr. Moor [5], it is known or strongly suggested that something illegal has gone on but there are doubt as to whether those kind of acts actually should be illegal).

Conflict arises over the nature of the action and over the attributes of the receiver of the action – most of this has been covered in sections 1. and 2. above and only has to be quickly summarised at this point. There are conflicts about the nature of the action – in the case of doctors and nurses, there are disagreements as to what the boundaries are between good or normal medical practice, bad medical practice or professional

misconduct, and deliberate killing (since Bland a separate category – see PVS case [9]) and murder. With respect to relatives, there are not so many uncertainties as regards their actions: it is quite clear what constitutes (an attempt at) killing. It is striking that in the case of the grandson, switching off a life-support machine is quite clearly seen by the newspapers as a ‘euthanasia attempt’, whereas the same action is already part of what is considered ‘normal medical practice’ and could be seen quite differently if performed by a doctor (BMA 2000).

Also there are conflicts as to the attributes of the receiver of the action. That can only mean that the same actions are seen differently if they are carried out on different people. This again suggests that distinctions are made between the treatment of different groups of people: the same treatment with respect to terminally ill people is ethically evaluated in a different way than if they were not terminally ill (see Chapter (7) on more about the way the press uses ‘terminal illness’ to justify euthanasia). The data suggests the possibility that this is also the case with respect to the judged competence of people, and even with respect to elderly as opposed to younger, and disabled as opposed to not disabled, people.

Conclusion

To sum up: 'euthanasia' in newspaper articles is invoked when doctors are involved in actions effecting, resulting in, or leading to death, no matter if or how ill the target person is. It is usually invoked by quoting someone who says something to the effect that this action 'amounts to euthanasia' - and often someone else denying that charge (for example: 'Placing elderly or terminally-ill patients under such restricted water regimes is a common practice to prevent them choking, but staff say the practice is being abused by some medics in what amounts to unofficial euthanasia' (Evening Standard, 6 January 1999)).

Sometimes there is unanimous agreement that the action differs from what is considered 'normal' medical practice, sometimes there is disagreement, between health professionals and relatives, or doctors and nurses, as to where the boundaries lie between good medical practice, professional misconduct or deliberate killing. Of course, doctors are not supposed to be involved in deliberate killing at all. However, the fact that what is considered to be good medical practice is shifting; this becomes clear in the PVS case [9]. Here, relatives apply with the support of their doctor to the state to ask to be allowed to discontinue feeding, intending death. Killing (that is not what it is called, although it could be) is seen as the business of the state, but the courts in their decision-making are relying heavily on the testimony of doctors as to what they consider to be good medical practice (see Tassano 1995, p.37). In the PVS case [9], acts that intend death come to be seen as good medical practice. In the coma case [10], this is (as yet?) more contentious.

In other cases, it is clear that a deliberate killing has been carried out by doctors. Here, 'euthanasia' is invoked appealing to leniency if the person was very ill and the doctor is seen to act out of motives of mercy; or, as in the Shipman case [13], the point is made that his killings did not constitute 'euthanasia', even though they were carried out by a doctor (which in fact makes them even crueler murders, as they are carried out by a trusted doctor). There is definitely a graded scale of acceptability as to the different action: euthanasia lies somewhere between good medical practice and murder.

The cases of 'euthanasia' involving relatives are euthanasia attempts gone awry, involving desperate measures. In the case of Vicky [3], pills are not working, the attempt

to smother with a pillow leads to a fall, the apparent paradox of wanting to kill but not wanting to hurt, finally calling the ambulance and making it public. Or in the case of Mr. Karapetian, the grandson [11]: barricading himself into the hospital room with his grandmother, fending off doctors and nurses, to do what he thought was the right thing. One can suspect that it is the drama of those cases that make them newsworthy, as opposed to more quiet attempts that work out as intended.

The case of the mother and relatives [6] bringing their disabled son back to life against the judgement of his doctors as to what in their view constitutes good medical practice is also dramatic (involving a physical fight with the doctors). In fact, in half the cases involving doctors, there is conflict between the doctors and the relatives. In the other half of the cases, doctors act on the wishes of relatives or relatives condone the acts of the doctors. Here, the conflict shifts to be with the state, holding the monopoly on killing, to examine whether any deliberate killing has taken place.

The purpose of the brief exercise in narrative analysis performed in this chapter is to give an overview of the content of the case stories linked to 'euthanasia' that have made it into the newspapers. This provides us with a context for the in-depth analysis in the next chapters. Chapters (7) in particular will look at particular themes that have come out of this chapter in rather more detail. One theme is the absence of the patients who are in the main incompetent and therefore 'acted upon' rather than acting. 'Euthanasia' in the articles refers therefore rather less to what is usually the object of discussion in the form of 'voluntary euthanasia', and more to the other, borderline practices situated between normal medical practice and killing. Whereas in discussions on voluntary euthanasia, the autonomy of the individual is stressed, here interdependence comes to the fore, giving rise to conflicts.

The next chapter will first of all look at the largest case in the sample, the Dr Moor case, drawing out the themes of particular relevance to its coverage in the press.

Chapter (6) - The Doctor Moor case and euthanasia in the press

Introduction

This chapter presents the findings of an in-depth analysis of the Dr Moor case, the largest case in the data set analysed for this thesis. The Dr Moor case involved a doctor tried before Newcastle Crown Court for the alleged murder of a patient. Taking place in 1999, it was reported in national and regional newspapers in April and May of that year.

The Dr Moor case is the story that got the greatest coverage in British newspapers in terms of the number of articles relating to it in the twelve months between November 1998 and October 1999. This is the time period for which all British newspaper articles were retrieved that came up in response to the search terms of ‘euthanasia’ on the newspaper search engine Lexis-Nexis. This period was selected on the basis of it representing the most recent time period for which articles were accessible through Lexis-Nexis at the time of the search.

The data are 48 articles that I have divided into the following three categories:

- 13 reports phase [1] (16. – 29. April 1999 – the murder trial)
- 17 reports phase [2] (11. – 16. May 1999 – the outcome of the trial, reactions to the outcome)
- 18 feature articles (12. – 16. May 1999 – substantial reflections on the trial and euthanasia in general)

This division will be helpful as there are some interesting differences in the presentation of the case between the original reports of the court case and the reactions to the eventual outcome of the case, as well as between the more factual reports and the more topic-oriented feature articles.

One difference is that originally, the focus of the articles is the murder case, with the press reporting from the position of the powers that be as represented by the law. Later on, after the verdict, the focus shifts to the question of euthanasia, with the press

increasingly representing voices of disagreement with court officials who try to ban euthanasia discussion from the court case. I will show that this is the case, and I will aim to address the question of the significance of that shift.

As the real issue arising from the Dr Moor case comes to be seen as the problem of euthanasia, there is extensive discussion about euthanasia in the phase [2] reports and feature articles. The second part of my analysis centers around the question: how is the problem of euthanasia dealt with in the press in relation to the Moor case? I will show that the press presents the debate in terms of two positions opposing one another in the phase [2] reports, but that we do not see that same opposition in the feature reports.

The shift from the murder case to the problem of euthanasia

This section will address the question of how and why the press shifts its focus, from reporting about a murder case to giving over to the question of euthanasia.

The best way of determining the focus of a newspaper article is to look at its headline. Headlines try to capture the reader's attention, enticing them to read the corresponding article. Therefore, headlines try to convey in one short phrase the condensed information of what an article is about, in a way that promises that apart from being informative, the article will also entertain. In that way, headlines tell the reader something about the focus of the article, the one aspect of the story that the editor of a paper judges will be most appreciated by the reader.

Phase [1] reports

The majority of the headlines of Phase [1] reports, the ones that initially give information about the murder trial of Dr Moor, center around a number. Typical headlines are:

‘ACCUSED GP ‘MAY HAVE KILLED 300’; DOCTOR ‘CONFESSED’ IN INTERVIEWS ON EUTHANASIA’ (The Guardian, 17 April 1999).

‘COURT TOLD GP MAY HAVE KILLED 300 PATIENTS’ (The Scotsman, 17 April 1999).

‘MURDER CHARGE DOCTOR MAY HAVE KILLED 300, COURT TOLD’ (Birmingham Post, 17 April 1999).

‘MERCY DOC COULD HAVE KILLED 300’ (The Mirror, 17 April 1999).

Phase [1] reports tell the story of how Dr Moor came to be charged of murder. The background to the trial according to the papers is that the doctor had said publicly (in newspapers and on television) that he was both supporting and practising euthanasia. Consequently, the police investigated and found one patient that Moor had referred to indirectly (having said that he had helped two patients to die in the same week) and brought him before court. In court, Dr Moor was accused of murdering that cancer patient by injecting him with an overdose of diamorphine. The number 300 comes from something Dr Moor is presented to have said to an NHS official: ‘I probably dealt with ten a year and have doing so for the last 30 years [...]’ (quote from article in the Western Daily Press, 17 April 1999, and others). The headlines suggest that Dr Moor is not a simple murderer, allegedly having killed one patient, but that he might be a mass murderer. Mass murderers are favourite subjects for newspapers as they satisfy the press’s penchant for sensationalism. The suggestion of horrendous and abhorrent crimes beyond comprehension is what is supposed to make the reader notice and read the article. What the articles themselves aim to do is give a ‘factual’ report of the background and circumstances of the court case, introducing the reader to a story that will continue in the papers as the case continues. The ‘facts’ reported are much the same in all phase [1] articles. They focus on the fact that Dr Moor is accused of killing a patient and that he denies that charge. They write that he has been charged with murder after he publicly ‘confessed’ (quote from the Guardian, above) to practising euthanasia, but that now in court he denies ever having practised euthanasia (‘I’ve never killed a patient – Murder jury hears doctor gave police a written statement denying he practised euthanasia’ – Evening Chronicle, 28 April 1999).

What is going on here? To understand that, one has to take a look at euthanasia and the law. British law forbids the killing of one human being by another. There are several categories in law that deal with homicide, for example murder and manslaughter, recognising that there can be differences in the circumstances of killings in terms of the responsibility of the person who killed. In cases of diminished responsibility on the part of the person who killed, the less serious offence of manslaughter is recognised and punished. The law as it stands does not recognise euthanasia or mercy killing as a separate category, as it could be conceived to be on the basis of the motive for the killing – compassion. Cases that could be understood as euthanasia cases are dealt with under the laws for murder and manslaughter. In practice, euthanasia cases that are recognised to be genuine are often dealt with under the category of the less serious offence of manslaughter.

Therefore, euthanasia killings are dealt with in the same way as other killings. The circumstances of the killing are of some interest from the point of view of the law, but euthanasia is still killing, and killing is prohibited in British law under all circumstances. It can be said that the initial reports of the Dr Moor case present the case from the point of view of the law. They mention euthanasia because Moor's public claims to support and practice euthanasia are what brought him to court in the first place which is important for understanding the background of the case, but it is not interesting in itself. No paper talks about euthanasia in other terms than as a different word for the word or the action of killing. Effectively, while the category of euthanasia is recognised in language as a category by there being a word for it, euthanasia does not exist as a category in law. It could be said that in law, the category of euthanasia is distributed out of existence (placed into the more general category of killing) in that the word has no legal meaning and the practices it relates to are dealt with under the laws for murder and manslaughter. The papers treat mercy killing as killing. Not only do they present the accused as a potential murderer, but a potential mass murderer.

As Dr Moor is accused of murder, the defense must show that he is not guilty of what he is accused of. The defense is quoted in the papers as alluding to the fact that the doctor did not deliberately kill his patient. The quote that appears in most papers is as follows:

‘Defense barrister Anthony Arlidge QC, told the jury: ‘Mr Liddell appeared to Dr Moor to be terminally ill. He was a very sick man. There was a time he was screaming out in agony. A doctor treating someone who is terminally ill is walking a tightrope. If he gives a high dose there’s a possibility the patient could die. Dr Moor did not set out deliberately to kill Mr Liddell, he was at all times trying to do the best for his patient as he saw it. He was trying to ease the suffering of someone very, very close to death. The Crown accepts that Dr Moor was not a wicked man and that he was caring and the question for the jury is was this caring doctor who tended patients for many years turned into a murderer. Our case is that he was not’ (The Herald, 17 April 1999 – the same or a very similar – shortened – quote appears in most papers).

The defense rests on several premises. First, the case is to be understood as resulting from a special relationship: the alleged murderer is a doctor and his alleged victim was a patient of his, who was terminally ill, who is already on the way to the process of dying, and treated by the doctor (for pain? The victim is presented as having been in pain). That treatment – the giving of medication - is presented as ‘walking a tightrope’. Walking a tightrope means that one could fall either way, it could turn out good or bad. This suggests that doctors have little influence on how a certain dose of medication will affect a patient, whether it will have the intended effects (of symptom relief) or result in the death of the patient. It presents the doctor treating a terminally ill patient as having the best interests of his patient at heart but the results of his treatment as effectively being beyond his control. The image of the ‘tightrope’ recurs even in the most shortened versions of the quote in other papers; it is its dramatic potential – in its meaning alluding to that general condition of humankind, the unpredictability, volatility, precariousness of human existence, events beyond our control, the workings of fate - that fits in with the entertainment value that newspapers aspire to, achieved through such dramatisation.

The defense of Dr Moor rests on the principle of the ‘double effect’, although no newspaper mentions anything of the double effect in their phase [1] reports. It is only in phase [2] reports, after Dr Moor has been cleared of murder on the basis of his defense, that the ‘double effect’ features. The ‘double effect’ is a concept that originally comes from theology, referring to actions that are done with the intention of doing good, but

might in themselves bear a risk of leading to a bad outcome. Here, even if it comes to the bad outcome, the good intention is judged to be of overriding importance. In medicine, it is currently regarded as legitimate for doctors to give their terminally ill patients increasing doses of morphine for their pain, even while knowing that such dosages increase the risk of death. This is what is referred to in medical ethics as the ‘double effect’. Pain relief has made huge progress over the last few decades. The hospice movement has been driving research in that direction. It is easy to forget how until recently not enough morphine was given to relieve pain even for a terminally ill patient because it was feared that the patient would become addicted. Even now, the reality of pain relief for many ill people is very much worse than would be expected looking at the knowledge that exists, as doctors are not well enough trained¹. Still, doctors who know about pain relief would not describe it in terms of ‘walking a tightrope’. They would argue that they are able to judge very well what quantity of morphine would bring about symptom relief and in what quantity it would immediately lead to death. In a terminally ill patient whose morphine dose has been increased over a long period of time, an overdose has to be considerable higher than for someone who has not been exposed to the substance. The argument is that in the normal practice of pain relief, on the basis of the knowledge that exists today, the death of a dying patient could be brought forward by hours or maybe a few days compared to when death would have come if there had been no intervention. Death is seen as imminent, ultimately caused by the disease. It is seen as strictly separate from euthanasia, where the action of the doctor is seen as the direct cause of the death of a patient, even if the disease would have killed him within hours or days anyway. As such, pain relief is not seen as problematic.

To recapitulate: phase [1] reports tell of a doctor who has to stand trial for the murder of his patient. His defense argued that there was no murder, that the death of the patient was the side-effect of pain-relieving treatment.

¹ See Melzack (1990) on doctors’ reluctance to prescribe enough morphine due to (unsubstantiated) fears of addiction, and Ruddick’s (1997) article ‘Do doctors undertreat pain?’, a question which he answers in the affirmative, explaining it with reference to doctors’ psychological and conceptual ‘forgetting’ of the reality of their patients’ pain.

Phase [2] reports

Phase [2] reports respond to the outcome of the court case. Dr Moor was cleared of murder. As the papers tell it: the jury found Dr Moor not guilty, siding with the defense in their judgement that what Dr Moor had done fell under the category of the double effect. They did so without knowledge of the actual dose of diamorphine that Moor had given, as the judge had ruled out the toxicological evidence as unreliable (something that critics see as crucial to being able to judge whether a massive overdose was given or whether normal pain relief was practiced). The reaction of the press to this outcome of the case can, again, be determined from the headlines. Some of the headlines of phase [2] reports are straightforwardly about the outcome of the case:

‘GP CLEARED OF PATIENT’S MURDER’ (Western Morning News, 12 May 1999).

‘GP CLEARED OF KILLING MAN DYING OF CANCER’ (The Scotsman, 12 May 1999).

‘DOC ACQUITTED OF ‘KILLING’ OF PATIENT’ (Belfast News Letter, 12 May 1999).

It is interesting to note that in the last two headlines, the very word ‘killing’ is being neutralised, by the device of inverted commas and by juxtaposing it with the word ‘dying’, implying that you can’t really kill someone who is already dying².

Other headlines focus on Dr Moor and his actions:

‘‘TIGHTROPE ALL DOCTORS WALK’ – GP CLEARED OF MURDERING PATIENT TELLS OF RISKS IN CARING FOR DYING’ (The Journal, 12 May 1999).

² This is an example of the ‘terminal illness discourse’ which is identified in Chapter (7) as a major discourse structuring the representation of euthanasia in the media.

‘‘ALL I TRIED TO DO WAS RELIEVE HIS AGONY, HIS DISTRESS AND SUFFERING’; DOCTOR CLEARED OF MURDERING PATIENT’ (The Guardian, 12 May 1999).

‘I’D DO THE SAME AGAIN, SAYS ACQUITTED GP – DR MOOR TELLS OF CLEAR CONSCIENCE’ (The Journal, 14 May 1999).

‘THOUSANDS OF DOCTORS ‘REASSURED BY VERDICT’’ (The Times, 12 May 1999).

As we can see, the tightrope metaphor appears again – the headlines all stress that in adverse circumstances, Dr Moor had done all that was in his powers to do for the good of his patient, he is at peace with himself and the world. Also, he has only done what other doctors are doing, the implication of the outcome of the court case for doctors in general being that they can all be secure in the knowledge that they are doing the right thing. An additional bonus resulting from the coverage of the court case may be the hope for doctors that the public has been educated by the newspapers about the ‘double effect’ and sensitised to the difficulties doctors face when caring for the dying, leading to a greater understanding of their role and actions.

Then there are those headlines that talk about euthanasia:

‘EUTHANASIA ‘VICTORY’ AS DEATH DOCTOR IS CLEARED’ (Daily Mail, 12 May 1999).

‘ARGUMENT ON ‘MERCY KILLINGS’ STILL RAGES’ (Birmingham Post, 12 May 1999).

‘VERDICT FUELS EUTHANASIA ROW IN MEDICAL WORLD’ (The Herald, 12 May 1999).

‘EUTHANASIA DEBATE’ (The Journal, 12 May 1999).

While the other headlines focus on the fact that the man accused of murder was found not guilty, that in fact what he had done was good medical practice, these headlines tell another story. Indeed, the very notion that here there was a court case that had to determine whether a murder had been taken place had been contested throughout the trial. The prosecution tried to uphold the normal procedure of determining whether the action that had taken place fitted into the particular category of offence – murder, and the defense argued within that framework that no murder had taken place by alluding to the ‘double effect’. Other interested parties, however, who got a say in the papers, took to questioning the very category of murder and asking whether this category was relevant to a case such as this one at all. The category of euthanasia was on the table from the very beginning. As I said before, Dr Moor was arrested in the first place after he publicly said he practiced euthanasia. From the beginning, the prosecution had to argue against the spectre of euthanasia:

‘From the outset, jurors were told that they were not considering the ethics of euthanasia. James Goss, QC, prosecuting, said in his opening submission: ‘This is not a trial about the merits of mercy killing. It is a straight forward case of a doctor deliberately ending the life of a patient in his care’ (Daily Telegraph, 12 May 1999).

In phase [1] reports, the press presents a murder case that is not about euthanasia. In phase [2] reports, after the outcome of the trial, the press concentrates on the problem of euthanasia. One could say that from accepting the rules of the law as the legitimate rules of the game, the press moved on to questioning those very rules. Seen from the perspective of the rules of law, the case had been straightforward: in a murder case, the suspect was found not guilty of murder. However, as different parties did not agree on what they considered to be murder and what they understood Dr Moor had done, in their category system, they necessarily had to interpret the verdict and its message in different ways. Instead of taking the rules of law for granted, they questioned their legitimacy, and the press gave room to those questions. Phase [2] reports report on the outcome of the

case, and then give a lot of room to reactions to the case. Most reports give a voice to the Voluntary Euthanasia Campaign who from the beginning had been present at the trial. The VES is a pressure group that campaigns for the legalisation of euthanasia. They necessarily looked at the case with an interest in assessing what it would mean for their cause, including presenting it in such a way that it must be seen as helping their cause. Then there is Peggy Norris from the anti-euthanasia pressure group ALERT. She has the function in the reports of presenting 'the other side'. The question of euthanasia is thus presented by the press in such a way that one could either be in favour or against it. I will look at this in detail in the second part of this chapter. The British Medical Association talks in support of the defense of the 'double effect'; Dr Moor repeats that he only tried to relieve suffering, and is careful not to talk about euthanasia.

The press, in their reports on the outcome of the trial, can be shown to interpret the Dr Moor case as in essence being a case that is primarily about the issue of euthanasia:

'The trial of family doctor Dave Moor focused public and expert opinion on the emotive and complicated issue of euthanasia' (Birmingham Post, 12 May 1999).

'The case is thought to be the first of its kind to be brought and has highlighted the controversial debate about euthanasia' (Western Morning News, 12 May 1999).

Everybody is said to be talking about euthanasia; not only the public, people like you and me, but the experts, people who know about things, are discussing it. Discussion is presented in terms of a 'debate' – 'controversial', 'emotive' – just what the press needs to attract readers. The term 'debate' is repeated in many articles: papers talk about a 'nationwide euthanasia debate' (The Journal, 14 May 1999), 'a national debate about euthanasia' (Daily Telegraph, 12 May 1999), 'the interminable debate about euthanasia' (Bristol Evening Post, 19 May 1999), 'reopened the euthanasia debate' (Birmingham Post, 12 May 1999), 'the euthanasia debate took off' (Daily Mail, 12 May 1999), 'the need for a widespread debate' (Western Daily Press, 12 May 1999). This debate includes each and every one of us, the whole world in fact: 'Everyone of us has our own view on euthanasia' (Bristol Evening Post, 13 May 1999) – 'EUTHANASIA AND DOCTOR

ASSISTED SUICIDE AROUND THE WORLD' (The Guardian, 12 May 1999). In effect, the press links the trial to a debate on euthanasia that is presented as having an existence independent of the trial as such. The Dr Moor case is used as the springboard to present that debate as topical and crucial to our lives here and now. The press highlights a need for discussion, hints that there be no easy answers as the debate has been longstanding and still not resolved, and promises to give the facts, to inform.

The press does that mainly through feature articles. These are articles that are not primarily about reporting on the court case and its outcome, including presenting reactions to it, but those articles that use the Dr Moor case as a reason to discuss issues that they present as having been brought into the spotlight by the case. Again, I take the headlines to be representative of the focus of the articles.

Feature articles

Generally, feature articles focus on euthanasia. They fall into three categories. There are those that interpret the outcome of the Dr Moor case as positive for patients and their rights, including the right to choose death:

'TRIUMPH FOR THE RIGHTS OF THE SICK' (The Mirror, 12 May 1999).

'VICTORY FOR A GP WITH COMPASSION AND COMMON SENSE'
(Birmingham Post, 13 May 1999).

Secondly, there are those that interpret the outcome as moving in the direction of giving doctors too much power over the life and death of their patients:

'DOCTORS MUST HELP US TO LIVE... NOT TO DIE' (Sunday Herald, 16 May 1999).

'DON'T LET THE LAW GIVE US A LICENCE TO KILL; COMMENTARY'
(Daily Mail, 12 May 1999).

‘WHY I WON’T EVER SUPPORT MERCY KILLING; HOSPICE DOCTOR ISSUES EUTHANASIA WARNING’ (Bristol Evening Post, 13 May 1999).

And thirdly, the majority of headlines speak of confusion, indecision and disagreement: guidelines for doctors on euthanasia are presented as inadequate and in need of renewing, the law as inadequate and in need of changing, there is no agreement over the ethics of euthanasia, we are confronted with choices we can’t deal with, we must therefore be interested in other countries: how do they deal with it?

‘BMA REVIEW OF DOCTORS’ ETHICS AND EUTHANASIA’ (Evening Standard, 12 May 1999).

‘HOW MEDICINE OFFERS AGONISING CHOICES’ (Northern Echo, 12 May 1999).

‘WE CAN NO LONGER DUCK EUTHANASIA LEGISLATION’ (Independent, 12 May 1999).

‘LIFE OR DEATH ISSUE NEEDS QUALIFICATION’ (Western Daily Press, 12 May 1999).

‘FOCUS: UNCOMFORTABLE ENDINGS; ASSISTED SUICIDE, MERCY KILLING OR MURDER? CAN WE EVER HOPE TO AGREE ON EUTHANASIA?’ (Independent, 16 May 1999).

Discussion of euthanasia in the wake of the Dr Moor case brings together the different aspects that are being debated by various groups that have an interest in the subject, like doctors who enter situations where euthanasia is potentially an issue, or the VES which campaigns for a right to die for terminally ill patients.

The next section looks at the different positions on euthanasia that are present in the coverage of the Dr Moor case.

What are the issues to do with euthanasia that are discussed in relation to the Dr Moor case, and how does the press present them?

As we have seen, British law does not recognise euthanasia as a separate category – it regards euthanasia to be in the same category as murder, and therefore to be illegal. The ‘double effect’ – defined as the potential and unintentional hastening of the death of a dying patient as a by-product of giving medication for pain relief – is generally considered to be legal. The Dr Moor trial reaffirmed everything of the above. Dr Moor admitted to having given the medication, the amount of which, however, could not be specified as the toxicological evidence was considered to be unreliable and therefore unusable by the judge. As it could not be proved that Dr Moor had given a dose considered to be high enough to having been deliberately intended to kill, the jury was left to speculate and decide on the intention of Dr Moor in giving the medication that resulted in the patient’s death. They sided with the defense and agreed that the death of the cancer patient had come about as a side effect of Dr Moor giving medication for pain relief, which is accepted and rationalised as the double effect. Therefore, Dr Moor was cleared of murder.

Positions taken in relation to euthanasia

This is a particularly interesting trial because it has invited responses that are in effect responses to the current state of the law, which is exemplified and reinforced by the outcome of the trial – murder (= euthanasia ≠ double effect) is illegal, the double effect (≠ euthanasia = murder) is legal³. Euthanasia, as a non-category in law and, with difficulties, banished from the court room, is nevertheless present in the newspaper coverage of the case. Responses to the outcome of the case are structured around an

³ ‘=’ reads ‘is the same as’; ‘≠’ reads ‘is different from’.

endorsement of the above boundaries or a questioning of them. There are four ways of setting those boundaries. I will set them out schematically and then explain them:

- (1) murder = euthanasia = double effect: killing

- (2) murder = euthanasia: intentional killing
 ≠ double effect: unintentional killing (result of treatment)

- (3) murder: unacceptable form of intentional killing
 ≠ euthanasia: acceptable form of intentional killing (choice and compassion)
 ≠ double effect: unintentional killing (result of treatment)

- (4) murder: unacceptable form of killing
 ≠ euthanasia = double effect: acceptable form of killing (choice and compassion)

These four positions summarise the four ways of setting the boundaries around the three practices. The outcome of all three actions is the same: the death of a person brought about by the action of another person. The scheme could become more complex for example by including the withdrawal of treatment, for example by switching off a ventilator (also an action that can lead to a death that people have different views on), but that is not what's being discussed in the Dr Moor case, so I will leave it out. Also, as the double effect is defined as a risk of death rather than leading directly to death, it could be seen as not fitting in very well into the scheme. However, that very definition of the double effect is contested, and the understanding of what constitutes the double effect in itself becomes an aspect of the particular boundaries drawn by the different positions. Similarly, the concept of euthanasia could be defined more closely - what I mean here is basically 'some form of euthanasia that could be described as voluntary or maybe non-voluntary, but not involuntary'. As we can see, the boundaries are defined by the application of different premises:

- a. killing is wrong
- b. intentional killing is wrong
- c. the unacceptable form of intentional killing is wrong

Those that see all killing as wrong (position 1) rest their view on the sanctity of life (which can be a secular understanding). They hold that is wrong under any circumstances to act in such a way as will result in ending the life of another human being. They are morally opposed to euthanasia, and see the double effect as problematic because to them it is a euphemism for euthanasia, or murder.

Then there are those that make a distinction on the basis of intention. There are two positions here, and they both rest on an acceptance of the double effect as bringing about death unintentionally, while murder and euthanasia are distinct for causing death intentionally. The position in law (position 2) is that murder and euthanasia, defined as intentional killing, are wrong. However, there is another view (position 3) that holds that not all intentional killing necessarily has to be wrong. They argue that euthanasia may be intentional killing, which nevertheless under certain circumstances could be acceptable and need not be wrong. As such, it is clearly distinct from murder, which they see as unacceptable intentional killing.

Lastly, there is the view (position 4) that does not accept the concept of intention as a legitimate tool for distinguishing between the different forms of killing. This view rates the double effect as equivalent to euthanasia on the grounds that both can be acceptable forms of killing, while murder, as an unacceptable form of killing, is considered to be wrong.

Positions taken in relation to euthanasia in the press

In the press, we do not see the positions spelt out as clearly as in this schematic presentation. I will now look at how the press presents the reactions to the outcome of the Moor case and the different views in relation to the 'double effect' and euthanasia. In this, the four positions outlined above will constitute a valuable way of sorting through the different views.

First of all, it has to be noted that newspaper articles are not giving complex overviews over complicated topics. They reduce complexity by presenting an argument as having two sides⁴. Articles are written in a style that sets up the two sides, or they are written from one of the two sides. Here are some examples of how the press sets up the debate in terms of two sides:

‘The trial has aroused controversy among pressure groups both for and against euthanasia [...]’ (The Herald, 12 May 1999).

‘Although the issue of euthanasia or ‘mercy killing’ was not addressed in court, both sides in the debate seized upon the ruling’ (The Journal, 12 May 1999).

‘Euthanasia [...] There are few issues in which those on both sides so routinely mire themselves in the shifting sands of rhetoric and prejudice’ (The Independent, 16 May 1999).

‘The trouble is that there is little clarity of thinking in the debate. The principle of ‘double effect’ separates the intention of an act from its consequences. Advocates of ‘mercy killing’ denounce this as a meaningless sophistry, insisting that it is used to cover up the fact that many doctors practice euthanasia without declaring it. Yet the same distinction is used effectively in courts to distinguish between murder and manslaughter. On the other side, those opposed to euthanasia talk about the ‘sanctity of life’ as though it were an absolute which, were it so, would rule out the notion of self-defense and force us all into pacifism’ (The Independent, 16 May 1999).

The two sides in relation to euthanasia: one could either be in favour of it, or against it, which is more implied than specified; it is as if the press finds it too self-evident to even mention. This last quote is typical in that it sets up the advocates of euthanasia against the

⁴ See Nelkin on the journalists presentation of scientific issues: ‘The quest for simplicity, drama and brevity precludes the complex, nuanced positions that scientists prefer. But the polarised presentation of technical disputes also reflects journalists’ norms of objectivity – their belief that verity can be established by balancing conflictual claims’ (Nelkin 1995, p.166/167). See also Chapter (3).

opponents to euthanasia. It does that by defining them through the different reasons they have to be opposed to the double effect. Comparing that to our earlier schema, we can see that ‘clarity of thinking’ is actually obstructed in the newspaper articles by trying to fit in everything into a system of two sides – for and against. This is what Nelkin (1995) showed to be the case for the reporting of complex scientific issues, and it seems to hold equally for the reporting of complex moral issues. In this respect, media discourse differs markedly from expert discourse, which is generally putting forward one particular argument while acknowledging the complexity of the matter.

Feature articles

Let us take a closer look at the feature articles. They can be divided into three categories. There are three that are written from a position that is obviously in favour of (the legalisation of) euthanasia. Four are arguing against the legalisation of euthanasia. The remaining nine are journalistic pieces trying to set out the problem ‘objectively’ – trying to give an account of ‘both sides’.

The articles in favour of euthanasia do not mention the ‘double effect’. They do argue in favour of euthanasia, therefore it can be said that they distinguish between acceptable and unacceptable forms of killing. In that sense, depending of what they would argue in relation to the double effect, they fall into either position (3) or (4) in the scheme outlined above. Those articles argue purely from the patient perspective. They show that there could be reasons for an individual not wanting to live any longer, particularly in situations where they ‘would have died anyway’.

‘Yet if a patient whose life has been all but destroyed by a debilitating and painful disease explicitly requests to be freed from their suffering, the only humane course of action is to comply’ (Birmingham Post, 13 May 1999).

‘But just because you are in pain does not mean your life is worth living. Is life in a coma worth living? Is life disabled and dribbling worth living? Maybe to some people it is. Many people can live life to the full even with a terminal illness... They

are right. Doctors cannot go around killing patients. But there are exceptions to every rule. If the only way to relieve suffering is to end life then for many people that is the right way. Every patient and every doctor should have the right to choose' (The Mirror, 12 May 1999).

In a way, those articles argue from what they perceive and present to be a common-sense perspective. It is implied that we can all sympathise that people can get into situations so painful and undignified that they do not want to live anymore. If people do not want to live any more in those circumstances, help them to die. Give people their choice. It is this common-sense sentiment that comes to be problematised by trying to define it in formal boundaries. What exact situation is bad enough so that we could allow that person to choose death? If the definition includes a certain condition or disability, does that imply a judgement about the objective quality of life of a person with that condition/disability? Does the attempted quantification of quality of life imply a judgement on the worth of life? Are we thereby denying the right to life to people in that category? The common-sense view does not have those problems. There need not be formal boundaries to assess the situation. It is trusted that common-sense recognises an individual situation that would justify euthanasia. The choice is made by the patient, and if those around him help him in carrying out his wish, they do so because they can sympathise with him or her. The view that euthanasia in those situations should be legal is more implied than spelt out.

The four articles that argue explicitly against the legalisation of euthanasia are all taking a very similar view. This is due to the fact that three of them are written by medical professionals, one by a nurse and two by hospice doctors – the fourth author being unspecified but arguing from the same position. All four strongly endorse the double effect. In a sense, it makes their practice possible. Their boundary is the intentional killing of patients, which they hold to be unacceptable under all circumstances. They say that a lot can be done to ensure that a patient will have a good death without killing him or her. They stress that a good nurse or doctor would prevent the use of burdensome treatment. Even though they hold that there are a few cases where euthanasia could be seen as acceptable, that is not enough to legalise the practice.

“There will always be a few cases when everybody agrees it would be much better for the patient if they died quickly. The problem is you can’t legalise for those few cases. Euthanasia is either legal for everyone or no-one” (Bristol Evening Post, 13 May 1999).

‘In my view such a manner of proceeding should remain illegal: though in a country such as ours in which more than half a million people a year die, there will always be some heartrending cases in which euthanasia would appear to be merciful, and to withhold it callous and uncaring. But it is an old adage that hard cases make bad law, and no law can be framed to cover every possible situation completely’ (Daily Mail, 12 May 1999).

They all expect negative consequences from legalisation – individual abuses through pressure and coercion with the result of people being killed against their wishes. They invoke the slippery slope which holds that voluntary euthanasia as a collective practice would necessarily get extended to the practice of involuntary euthanasia, and that even if there were no additional deaths, groups like the elderly would live their life in terror, frightened of being killed against their will. The hospice doctors argue that the legalisation of euthanasia would divide attention and resources away from the necessary improvement of palliative care – they hold that there are other things that need improving in the care of the dying, like educating doctors, before one should start thinking about euthanasia:

‘My fear is that some doctors – and they are very caring and want to do the right thing – don’t realise all the options that are available today in modern palliative care. They tell themselves that they have no option but to help a patient to die. This is the problem which faces caring doctors today. It will become much worse if we have legalised euthanasia’ (The Journal, 13 May 1999).

Interestingly, one article talks about the possibility of a stricter law:

‘Would we really want an even stricter law which forbade doctors to alleviate suffering during a patient’s last few hours or days? It would be a great shame if a perfectly satisfactory legal doctrine were abandoned’ (The Journal, 13 May 1999).

In effect, the four articles arguing against the legalisation of euthanasia all agree with the present state of the law. They fall into position (2) as outlined above. It is interesting to see that position (1), the strong view that all killing is wrong, including the double effect, does not have an independent voice in the feature articles. That is even more interesting as in phase [2] reports, the Voluntary Euthanasia Society (who are altering between positions (3) and (4)) is set up in opposition to the anti-euthanasia group Alert:

‘Peggy Norris, chairwoman of the anti-euthanasia group Alert, said: ‘I think this is a sad day for medicine as it makes the law unclear as to what is allowed. We cannot have a half-law when it comes to this’’ (The Guardian, 12 May 1999).

‘Dr Peggy Norris and her pressure group Alert are totally opposed to all attempts to have euthanasia legalised or decriminalised: ‘It is not simply a matter of law – it is an ethical and a moral issue’, she said’ (The Journal, 12 May 1999).

Here we come closest to the strong position against all killing (position 1), as the outcome of the Moor case and its acceptance of the double effect is seen to make the law on killing unclear, suggesting that Alert does not accept the concept of intention to justify a division between what they must see as different forms of killing. It seems that in phase [2] reports, position (1) is set up against position (3) or (4) for a dramatic effect, while in the feature articles the case for legalisation is made by position (3) or (4) and the case against by position (2), the defense of the status quo. The strong view on killing (position (1)) is all but absent.

Now we still have to look at the remaining nine feature articles that don’t argue from one particular position, instead attempting to map out the debate – which, of course, does not mean that individual articles might not lean more towards one position than another.

The double effect features prominently in the majority of articles. Out of the five articles that discuss the 'double effect', four present it as being problematic:

'Powerful pain killing drugs used to alleviate a patient's suffering may, in some cases, actually hasten death. This creates a dreadful conflict of interest among doctors who have pledged to save life but also feel obliged to give patients a pain-free death. It can also open a doctor up to the charge of murder' (The Northern Echo, 12 May 1999).

'In the past, that decision could be made discreetly. The law of 'double effect' which allows doctors to administer as much painkiller as is needed to relieve the suffering while ignoring the fact that this dosage would actually kill the patient won't wash any longer in a world of negligence actions and pressure groups demanding clarification of 'hypocrisy'' (Independent, 12 May 1999).

'When does administering drugs to cut back on agony and distress overstep the bounds of acceptability and become the intention to hasten the end? And if it does so is that so wrong if there is no hope of recovery and the agony is causing such distress that both patient and family wish a dignified and speedy end to the suffering?' (Western Daily Press, 12 May 1999).

'Is the doctor giving diamorphine to relieve pain? Or to shorten life? And can you meaningfully separate the two, as the present law purports to do with the principle it calls 'double effect'?' (Independent, 16 May 1999).

The first quote about the 'double effect' creating a dreadful conflict of interest among doctors is very much at odds with what doctors themselves have said in the articles discussed above. For those doctors, the 'double effect' is a tool that works well for their practice, allowing them to uphold the boundary between killing and not killing. The other three quotes effectively question whether separating intention from consequences, as the 'double effect' does, is legitimate. They argue that what is 'really' going on is killing, so

we should be open about it. The Independent argues that we cannot have doctors secretly killing off patients, while the Western Daily Press puts forward the view that, maybe, killing need not always be considered a bad thing, and there would be merit in acknowledging this openly. The four articles do not separate the ‘double effect’ as being in a completely separate category from euthanasia. However, the fact that the double effect is presented as being a confused and not quite satisfactory solution to a complicated and confusing problem might partly be a dramatic device, considering that it only leads to strong demands in terms of a change in the law in two cases. One, after exposing the unsatisfactory nature of the ‘double effect’, actually argues that the law we have at the moment ‘may be as good as we are likely to get’ (Independent, 16 May 1999) (interestingly, only 4 days earlier the same paper made a strong case in favour of change in the law: ‘The law will have to be clarified and the Government will have to bring in new legislation’ – Independent, 12 May 1999). It arrives at that conclusion after a discussion of the arguments of campaigners for and against euthanasia (position (1) set up against position (3) or (4)) and the expected consequences that the legalisation of euthanasia would be likely to have, arguing that moral arguments tell us less about what would happen than a look at how society actually works. It concludes that with pressures coming from many different directions (for examples pressures on budgets in the NHS), the practice of legalised euthanasia would be structured by cultural elements such as who is valued in our society – and those less valued are better protected by the law as it stands.

The fifth article talking about the ‘double effect’ does so in defense of it. It argues that the law is perfectly clear and right, that the euthanasia debate is straightforward and any confusion about matters has been generated by ‘lazy newspaper headlines and the Voluntary Euthanasia Society, who has called for the law to be clarified’ (Sunday Times, 16 May 1999). The whole article is a perfect exposition of position (2), accepting that euthanasia is murder and the double effect legitimate and useful in medical practice. The position of the VES is criticised from that position, centering around their relation to the ‘double effect’:

'[...]the VES immediately spread confusion by saying that Moor had performed 'slow euthanasia'. This was grossly untrue. Euthanasia is intentional killing[...] By acquitting him, the jury effectively 'double effect' and the crucial legal principle that intention is what matters. In doing so, it presented the VES with a difficulty. The society doesn't accept the validity of the double effect and the importance of intention. Stating it was 'overjoyed' at Moor's acquittal, it repeated its mantra that double effect was a 'hypocritical situation which had to change'. Yet at the same time John Oliver, the society's general secretary, completely contradicted this by saying that the defense of double effect was a valid one' (Sunday Times, 16 May 1999).

The confusion created by the VES, criticised by this article, is that they are not consistent in their position regarding the double effect. They are shown to oscillate between position (3) and (4). What both positions have in common is that they believe that there are some acceptable forms of killing. The stated aim of the VES is to campaign for the legalisation of voluntary euthanasia. Whether they accept the concept of intention crucial to the double effect or not is irrelevant to them, as their boundary lies between acceptable and unacceptable forms of killing, while it is crucial for people who draw their boundaries at intentional killing. Their interest in presenting their position to the 'double effect' can only really be a tactical move on the way to achieving their goal. They have no problem in accepting the validity of the 'double effect', but they can just as well make use of it by calling it 'slow euthanasia', which fits with their view that the real distinction should be between euthanasia as acceptable killing and murder as unacceptable killing. In that way, they do not really see a difference between giving an injection of painkillers while accepting that it could lead to death and giving a lethal injection that necessarily will lead to death – especially as in practice, they see the double effect as able to hide instances of intentional killing. However, the Sunday Times article is not really interested in the logic of the reasoning of the VES, as it objects to its ultimate goal: the legalisation of euthanasia. It objects to the way 'euthanasia has become presented as a right, dressed up in the language of choice and dignity' - 'a trump card in a society which so venerates personal autonomy'. The reasons given for why this should not justify the legalisation of

voluntary euthanasia are firstly, that ‘good palliative care obviates the distress that fuels calls to legalise euthanasia’, and secondly, that ‘voluntary euthanasia is a slippery slope to killing without consent’. Actually, we find evidence of the existence of the slippery slope in the thinking of the author, because when talking about voluntary euthanasia, she makes the conjecture that ‘doctors and lawyers will increasingly decide whose life has any meaning’ in relation to incompetent people. Here we have the overstepping of a boundary that is crucial for the VES, which is that they campaign for ‘voluntary’ euthanasia, involving choice on the part of a competent patient. For the author, however, there is no firm boundary between voluntary, involuntary and non-voluntary euthanasia – her strong boundary is between intentional killing and unintentional killing. Any intentional killing is wrong, whether it involves a request on the part of a competent patient or a person in a Persistent Vegetative State.

Conclusion

It has been demonstrated how press coverage of the Dr Moor case has changed over time, from concentrating on the aspect of murder to shifting to a discussion of euthanasia.

The concept of the ‘double effect’, central to the court case, also formed the core of press coverage in the 2nd phase articles. The ‘double effect’ represents a practical tool for doctors in that it upholds the boundary between ‘killing’ and ‘not killing’, defining actions that doctors can do (actions equivalent to ‘not killing’) and cannot do (actions equivalent to ‘killing’).

This boundary between ‘killing’ and ‘not killing’ appeared as a contested one in the press coverage of the Dr Moor case. Killing itself was not universally condemned, rather there exist three positions in relation to killing: (1) that killing is always wrong, (2) that intentional killing is what is wrong, and (3) the only the unacceptable form of intentional killing is wrong. In reports on the Dr Moor case, the position that killing (intentional or not) is always wrong appears in contradistinction to the position that there are some acceptable forms of intentional killing, thus setting up the issue of euthanasia as the opposition between people in favour of killing and people who are against killing. However, in more detailed discussion of euthanasia, press discourse all but marginalises

the position that killing (intentional or not) is always wrong – here the supporters of the moral rightness of some acceptable form of intentional killing are opposed by defenders of the status quo which suggests that only intentional killing is wrong (not unintentional killing).

In the next chapter, we will see how press discourse justifies some forms of killing, not with reference to intent but by a move to divert responsibility for killing away from the human actor.

Chapter (7) – Discourses structuring the press coverage of euthanasia cases: the ‘voluntary euthanasia discourse’ and the ‘terminal illness discourse’

Introduction

This chapter will be looking at the discourses that structure the press coverage of euthanasia cases. The discourse in terms of which experts discuss euthanasia – the ‘voluntary euthanasia discourse’ – is identified as taking the role of a *minor discourse* in newspaper coverage. The *major discourse* having a bearing on the way in which the press conceives of euthanasia cases I will call the ‘terminal illness discourse’. Both the ‘voluntary euthanasia discourse’ and the ‘terminal illness discourse’ will be discussed in this chapter in terms of how they assess agency, and how they assign responsibility in particular situations both to humans and to non-human entities.

Euthanasia as a problem

Euthanasia, as is often pointed out by different parties in the debate, has always existed. It is a point of dispute whether the legalisation of euthanasia would increase or decrease its incidence. But euthanasia has not always been a problem. Problems are socially constructed. A certain situation has to be perceived as a problem. And even when it is generally recognised that there is a problem, different points of view lead to different perceptions of what the real problem is.

The media in my sample from 1998/99 recognise euthanasia as a problem (the reasons and pressures leading to euthanasia having become a problem, not just in the press but in wider society, will not be discussed here – one writer who has addressed this question is Emanuel 1994 – see also Chapter (1)). This problem can be presented in two ways: as a question of morality, of right and wrong, and as a question of management, centering around legalisation. While the former has a bearing on the latter, the two can be distinguished analytically as they address quite different concerns. To concede that

euthanasia could be right in certain circumstances can, but does not have to, lead to calls for legalisation, whereas legalisation does not need to entail that euthanasia is seen as something desired, good or right. In the press, on the other hand, the ‘case for euthanasia’ (moral) and the ‘case for the legalisation of euthanasia’ (management) often get conflated:

‘In theory the case for euthanasia is straightforward. Some people suffering from painful, incurable or humiliating illness would prefer to die swiftly and without pain. If their doctors are happy to assist them to suicide, the state should not interfere with the free, informed choices of its citizens in matters that do not cause others harm. The case against is equally plain. Every life has intrinsic value, irrespective of the individual's mental state or physical condition. Agreeing to clinical homicide in the heart-rending cases would be the start of a "slippery slope" in which today's right to die would become tomorrow's duty to do so.’ (The Independent, 16 May 1999).

Here, discussion of the ‘case for euthanasia’ is made in legal, not moral terms – in terms of the ‘state’ and the ‘informed choices of citizens’. The ‘case against’ addresses a problem of management – in terms of a ‘slippery slope’ that would lead to abuse.

However, the quote also refers to the ‘intrinsic value’ of every life, a moral evaluation: this is not seen as out of place, but part of the same problem. This is a good example for how the press treats euthanasia as a moral problem, and euthanasia as a management problem, not as separate, but as the same: the moral case for or against euthanasia and the legal case for or against euthanasia are treated as the same problem. In other words, whereas ‘euthanasia’ is problematised by the press, the connection between laws and morals is not problematised – it is taken for granted that their connection is straightforward and well understood, that one necessarily follows the other. It appears that press discourse tends to conflate issues that ‘expert’ discourse aims at separating: ‘experts’ on management and ‘experts’ on morality generally belong to different fields of expertise.

This conclusion is also corroborated by the way the Moor case is understood by the press - it is just as likely to see the Moor case as addressing the problem of the management - or legalisation - of euthanasia:

But the case - and public interest in it - centred on whether doctors should legally be able deliberately to end a terminally ill patient's life (Birmingham Post, 12 May 1999).

- as it is to see it as addressing the problem of the morals of euthanasia:

The case has ignited a nationwide debate about the rights and wrongs of hastening the deaths of terminally ill patients (The Guardian, 12 May 1999).

As I said before, it is not that there doesn't exist a connection between morality and law, in fact it is a very complex and problematic one. However, the point I am making here is that the press agrees to see euthanasia as a problem, but is less sure whether the problem is the management or the morality of euthanasia. In the event, both aspects become conflated.

In general, the emphasis in the press is on the problem of the legalisation of euthanasia. The moral aspect is subordinated to this problem, and moral arguments are made in support for or against the legalisation of euthanasia. On the whole, however, there is a tendency to equate morals with the case against euthanasia – the role of moral guardians is given to anti-euthanasia activists:

Dr Peggy Norris and her pressure group Alert are totally opposed to all attempts to have euthanasia legalised or decriminalised. "It is not simply a matter of law - it is an ethical and a moral issue," she said (The Journal, 12 May 1999).

In general, the legal case for euthanasia centres around the right to choose the circumstances of an individual's own death to become enshrined in law, while the legal case against addresses the possibility of abuse, individuals being killed against their will – as seen in the first quote above.

The moral case is generally automatically the case against legalisation, and the case for the legalisation of euthanasia in general does not need a moral argument: the morality

of making the individual the centre of decision-making is already shared by the doctrine of the liberal state and the idea that individuals should be allowed to choose the circumstances of their deaths¹.

Due to this congruence, the particular morality that involves seeing the individual as the centre of things becomes obscured, and morality becomes automatically linked to arguments that argue from positions other than the individual: whether that be from a concept of the 'sanctity of life' deriving from a source beyond the individual, be that God or nature; or from the idea of society conceived as a moral collectivity rather than as a collection of individuals.

Again, the latter (society) is a candidate for confusion: writers don't seem to be too sure whether to see society as a source of collective morality or an entity to be managed. It can be seen as both, of course, and just as in the case of the legalisation for euthanasia and the morality of euthanasia, the two can only be separated analytically, in order to be able to look at the way in which they are connected and understood to be connected.

To sum up, the press presents euthanasia as a problem, the nature of which is perceived to be legal-moral.

'Voluntary euthanasia discourse' and 'terminal illness discourse'

In Chapter (4), I have given an overview of the representation of euthanasia in expert debates. Experts coming from different fields of expertise, aligned with particular institutions and interests, are concerned with particular aspects of euthanasia and with developing particular definitions that compete against other particular definitions to become the generally accepted definition.

Doctors are interested in the distinction between active and passive euthanasia, because it relates to their actions and brands them as killing or not killing; patients are interested in the distinction between voluntary and involuntary euthanasia, because it relates to their wishes regarding killing or not killing. Looking from the outside, as I have

¹ See Billig (1989) on the importance of the ideas of liberalism for contemporary ideology. Billig's analysis of the dilemmatic aspects of thinking includes an awareness of the historical creation of thinking, of how 'our concepts and our ideas reflect the history which has produced these current moments' (Billig 1989,

done in Chapter (4), ‘expert discourse’ on euthanasia on the whole appears to be a contested field of knowledge and expertise, made up of contested categories and boundaries. ‘Euthanasia’ is hardly ever discussed without a qualifying adjective.

In the newspaper reports, this is very different. ‘Euthanasia’ hardly appears with a qualifying adjective. In the 132 articles that make up the case stories discussed in detail in the previous chapter, the word ‘euthanasia’ appears 467 times, mainly unqualified. The ones that are qualified include 58 mentions of ‘voluntary euthanasia’ (35, that is more than half, of which appear in the name ‘Voluntary Euthanasia Society’), 4 mentions of ‘involuntary euthanasia’, none of ‘non-voluntary euthanasia’, 1 mention of ‘active euthanasia’ and none of ‘passive euthanasia’.

This leads me to wonder whether it could be that ‘voluntary euthanasia discourse’ is so engrained in press discourse on euthanasia, that many times when the term ‘euthanasia’ is used, it is intended and understood as a shorthand for ‘voluntary euthanasia’².

The question is: how should we understand this mainly unqualified use of the word ‘euthanasia’ in the press? To answer that question, we have to look at how euthanasia is discussed in the context of euthanasia cases.

In ‘expert discourse’, the most generally accepted distinction between different forms of euthanasia appears to be the one between voluntary and involuntary euthanasia. It is the same distinction that the Voluntary Euthanasia Society defends, seen in its choice of

p.3). Liberalism today contains opposing themes which allows for endless debate and argument, sometimes overtly, or, like in this example, covertly by providing the underlying structure of the argument.

² A small informal questionnaire distributed among ten colleagues (PhD students in sociology at Goldsmiths College) suggests that this may well be the case. The questions asked were:

1. Have you ever (for whatever reason) given any thought to ‘euthanasia’? Yes/no – elaborate if you wish to
2. How do you understand the term ‘euthanasia’?
3. Do you have any particular opinion on ‘euthanasia’? Please explain:
 - no, not really
 - yes, I think that...
 - yes, I feel quite strongly that...
4. Have you got any further comments?

In relation to question (2), which asks how they understand the term ‘euthanasia’, every single one gives it the meaning of ‘voluntary euthanasia’ or ‘assisted suicide’. Here are two examples: ‘choosing when you die – in a situation of pain or terminal illness’; ‘informed consensual assistance to die (preferably written and signed) by both parties in the presence of trusted witnesses’.

name. This distinction rests on the opposition between choice and coercion, between an individual wanting to be killed and an individual being killed against his or her will.

The question to ask that problematises this distinction would be: how voluntary is a particular case of euthanasia? 'Voluntary' can mean at least five different things:

5 kinds of 'voluntary'	5 reasons that make it less than 'voluntary'
Ask for euthanasia out of his or her own free will	There is no such thing as free will (social values become internalised, for example that the old, the disabled are worthless)
Ask for euthanasia after consultation of others (for example family)	Consultation with others (who can have good or bad intentions) leads to pressures to ask for euthanasia when this is not what the person really wants
Consent to euthanasia after the doctor has proposed it	The person consents for the wrong reasons, found in the unequal patient-doctor relationship, where the doctor has the power to define the situation – the doctor can have the 'best interest' of the patient at heart or act with other motives (personal or institutional)
Having asked for euthanasia in the past (living will)	The person might change her mind
There is reason to believe that the person would approve of euthanasia (indicators: religious affiliation, general personal values, ethical orientation...)	This relies on close knowledge of the person, could be the wrong understanding leading to the wrong conclusion, or the person could be intentionally misrepresented

All of these uses of the term ‘voluntary’ as well as the objections have been used at one time or another in the euthanasia debate or court cases relating to euthanasia (see Keown 1998).

What is immediately striking regarding this table is that it is the complexity of social interactions that appears to render an initially straightforward concept problematic. It also illustrates how complex situations can be defined by the mere application of a word: to call a case of euthanasia, where the dying person is not capable of voicing her wishes, ‘voluntary’ – when ‘voluntary’ has a positive meaning – is to evaluate the situation in a particular way as well as to justify it. The next question to ask, then, would be: who is talking, where are they coming from and what is the context? – as what we will now be dealing with is likely to be a difference in the evaluation/appreciation of a situation, relating to different interests of the speakers. On the other hand, if all speakers agreed, this would be interesting in itself and raise the question of how this uniform understanding could have been achieved.

The use of the word ‘voluntary’ in what I will call the ‘voluntary euthanasia discourse’ has taken root in press coverage of euthanasia. Two striking examples of that come from the Coma case [10] and the Dr Moor case [5] respectively. In the Coma case, a husband asks the court to be allowed to withdraw artificial nutrition and hydration from his wife who has been in a coma for over six months. Her mother supports his case by saying that her daughter had said to her in the past that she wouldn’t want to live ‘like that’, that is in a coma. In the event, she is quoted by the newspaper applying a very loose definition of ‘voluntary’:

‘Seeing Lorraine like this has made me even more sure that voluntary euthanasia should be legalised’, she said. ‘If I could give her some kind of injection now, I would’ (Daily Mail, 26 August 1999).

This use of the word ‘voluntary’ can be defended as can be seen from the table above: according to the table, the mention of not wanting to live ‘like that’ could be interpreted as some kind of ‘living will’. However, the application of the concept ‘voluntary’ to this situation can relatively easily be challenged. Thus, the important thing to note here is that

the author of the newspaper article left that comment unchallenged, which could lead to the conclusion that ‘voluntary euthanasia discourse’ is seen as legitimate by the press, even when it is applied to unlikely cases.

This conclusion is strengthened by the following example from the coverage of the Dr Moor case – this court case aimed to establish whether Dr Moor had given an overdose of diamorphine to a terminally ill patient. Even though, throughout the press coverage, there is nowhere a mention that this patient asked or was even in a position to ask for euthanasia, one can read the following by a member of the VES quoted as saying:

‘Dr Moor was responding to his patient’s request – he wanted to relieve his suffering. To me, this not guilty verdict shows that slow euthanasia is alive and well’ (the Journal, 12 May 1999).

Again, this application of ‘voluntary euthanasia discourse’ to a situation where it apparently does not apply goes unchallenged by the journalist, which suggests that the legitimacy of ‘voluntary euthanasia discourse’ is such that it is accepted without too much questioning.

The ‘voluntary euthanasia discourse’ might have some presence in the newspaper coverage of euthanasia, but looking at the treatment of the different cases, it becomes apparent that another contrast to the one that the ‘voluntary euthanasia discourse’ is based on is of greater importance in the press. Euthanasia in terms of ‘choice’ or ‘coercion’ (from the point of view of the one being killed) gives way to the external evaluation of the cases in terms of ‘tragic’ as opposed to ‘criminal’. This is by no means the same thing, although it might appear so to start with. But one should not make the mistake of equating ‘choice’ with ‘tragic’, and ‘coercion’ with ‘criminal’. Choice/coercion and tragic/criminal do not map onto each other, they do not mean the same thing.

The pair choice/coercion rests on the idea that the individual relies on internal forces that lead her to make decisions; decisions that can be falsified by outside influence. It rests on what Barnes calls:

[...] the stereotype of the independent individual: independently chosen actions are normal, good and moral, and social influences on action are potentially causes of lapses from what is normal, good and moral (Barnes 2000, p.61).

Individually chosen actions are good, social influence is bad. This characterisation runs through the whole of the euthanasia debate: the idea of being able to carve out a realm where an individual can freely chose to die, free from external constraints on her decision (a notable exception is Boyd discussed in Chapter (4), who introduces the idea that a ‘conversation’ between patient and those around him must be at the heart of a decision-making process). By attempting to create such a realm,

A domain for action devoid of external interference has been sought, and the explicit demand has been for an area of ‘free choice’, one where the individual has a ‘right to choose’ created by withdrawal of external constraint. In this discourse choice features as absence, and the problem of the nature of free agency never arises (Barnes 2000, p.145).

In the choice/coercion opposition, agency rests either with one person or another/others. Somebody or other can be held responsible – this relates to what Barnes call the ‘institution of responsible action’. Voluntaristic discourse rests on the idea that individuals chose their actions, that they could always have chosen otherwise.

Yet, there is another paradigm that can account for action: the ‘institution of causal connection’. In Barnes words, ‘choice is said to exist only where causation is not, and a domain of voluntary action is created beyond the reach of ordinary causal explanation’ (Barnes 2000, p.3). Choice and causation thus appear as mutually exclusive – but Barnes also says that ‘much of our everyday discourse manifests a robust compatibilism, in that it is content to regard actions as at once chosen and caused’ (Barnes, 2000, p.4).

This is where I get to my next contrast: the one between ‘criminal’ and ‘tragic’, which is important in the press. Whereas the ‘voluntary euthanasia discourse’ rests on a particular stereotype of the individual, the ‘institution of responsible action’, and choice as absence, this ‘press discourse’ introduces the ‘institution of causal connection’, and the

cause is terminal illness. Just as in the ‘voluntary euthanasia discourse’ the central notion of ‘voluntary’ can become inflated, in this ‘press discourse’, the central notion of terminal illness gets extended: from the terminal state of an incurable illness, to incurable illness, to other kinds of states (coma or PVS).

We generally hold that individuals who chose their actions are to be held responsible for them, but that an individual whose action is caused by something beyond her is to be seen as less responsible. Terminal illness in ‘press discourse’ is established as such a cause that results in individuals being regarded as less responsible. Euthanasia cases that involve terminal illness are presented as ‘tragic’³ in newspapers. It is the absence of terminal illness in cases that invoke euthanasia that inspires the press to present them as ‘criminal’.

As I said before, it is clear that newspaper discourse draws on ‘voluntary euthanasia discourse’. But ‘terminal illness discourse’ is the dominant one in newspapers, and it pulls in another direction than the ‘VE discourse’. I will attempt to show this in the following diagram:

³ In its literary meaning, ‘tragic’ derives from ‘tragedy’. A tragedy is a drama about the inner dynamics of humankind’s response to destiny. While stressing man’s fate, it does not deny him freedom to act (the protagonists of tragedy used to be mainly men). The structure of the drama revolves around notions of dilemma, choice, wretchedness of soul, as well as guilt. In Sewall’s words,

‘Only man in action, man ‘on the way’, begins to reveal the possibilities of his nature for good and bad and for both at once. And only in the most pressing kinds of action, action that involves the ultimate risk and pushes him to the very limits, are the fullest possibilities revealed. It is action entered into by choice and thus one which affirms man’s freedom. And it leads to suffering – but choice of a certain kind and suffering of a certain kind. The choice is not that of a clear good and a clear evil; it involves both, in unclear mixture, and presents a dilemma. The suffering is not so much that of physical ordeal (although that can be part of it) but of mental or spiritual anguish as the protagonist acts in the knowledge that what he feels he must do is in some sense wrong – as he sees himself at once both good and bad, justified yet unjustified. This kind of suffering presupposes man’s ability to understand the full context and implications of his action, and thus it is suffering beyond the reach of the immature or brutish, the confirmed optimist or pessimist, or the merely indifferent’ (Sewall 2001).

The literary vision of tragedy thus deals with the ambiguity at the heart of human life, the ambiguity in our own nature and the world around us that has to be endured and cannot be solved. I have chosen the term ‘tragic’ to denote the press discourse of terminal illness in relation to euthanasia because it shares some elements of the literary vision of tragedy: the press version of the tragic borrows from this literary vision the notions of dilemma and choice, the struggle of man with forces beyond him (destiny in the form of terminal illness), but it puts less emphasis of the elements of wretchedness of soul and guilt. As we will see in the following, the vision of ambiguity at the heart of human life of the literary meaning of tragedy gives way to advocacy of particular actions in the face of destiny (terminal illness) in the press discourse, as if that ambiguity could be solved. The press vision of the tragic can therefore be said to have ultimately lost the essential core of the literary meaning of tragedy

		Choice	
		yes	no
Terminal illness	yes		
	no		

As we can see from this diagram, the discourse coming from the perspective of choice and the one centering around terminal illness do overlap, suggesting that euthanasia cases where both choice and terminal illness are present are doubly legitimated.

However, if the central notion of ‘voluntary euthanasia discourse’ is choice, then, even if the presence of terminal illness is implicitly accepted, it has a tendency of spreading to be applied to cases without terminal illness.

If the central notion is terminal illness, even if choice is implicitly accepted, it has a tendency to spread beyond cases where the individual has chosen herself. And this is what I think we can find in the press discourse, in what I will call the ‘terminal illness discourse’. I will now go on to substantiate this claim with some examples.

Tragic cases - the Dr Moor case [5]

Dr Moor was arrested for the alleged murder of a terminally ill patient. The court found that he was not guilty, on the basis that he did not administer an overdose of diamorphine with the intent of killing, but a dose adequate to relieve pain. A more detailed account of the newspaper coverage of the Moor case was presented in Chapter (6).

There are two phases in the reporting of the case: the first phase is reporting the arrest of a potential criminal, not just a potential murderer but a potential mass-murderer. Phase

one of the reporting presents the case as *criminal*, where Dr Moor is presented to be at least potentially a fully responsible agent of a crime. The second phase comes after the verdict of not guilty, where Moor is cast by the press as a hero, a caring and humane doctor who has stood up for the rights of the dying and euthanasia, although he has done nothing like that in court, having pointed to his actions as normal medical practice, not euthanasia.

This phase two in the reporting shifts the case into the realm of the *tragic*, where agency and responsibility are shifted away from Dr Moor, and attention to terminal illness as the primary cause for the situation takes over. Dr Moor is presented as responding to that situation. The patient is presented as a terminally ill man, he is never reported to have spoken at all, let alone about his wishes about dying or being killed, he is only reported to have screamed in pain. In reaction to that, Dr Moor is said to have given an overdose, or a dose adequate to relieve pain, of diamorphine. The court found the latter to be the case, but quite apart from that, there is a unanimous acceptance in the press that the patient had not asked to be killed.

The court found Dr Moor had done nothing approaching euthanasia, but the press talks about the case as a case about ‘the rights and wrongs of hastening the deaths of terminally ill patients’ (see earlier quote) – note that there is no mention here of choice. The press accepts that the Moor case has a bearing on the issue of euthanasia; if we accept this, then we are dealing with a euthanasia case that involved a patient who did not chose euthanasia, which leads to the conclusion that the sympathy of the press is not primarily triggered by the wishes of the dying but by what is perceived as the plight of the terminally ill.

We have also seen above (p. 185) that voluntary euthanasia discourse (‘his patient’s request’) gets applied to this case of a patient who has not made any request, going unchallenged by the journalist. On the other hand, consider the following quote:

The pro-euthanasia lobby believes that if someone is suffering pain, has a terminal illness and is dying or being prescribed drugs that are killing them, they should be able to die with dignity (Northern Echo, 12 May 1999).

Whereas the main argument in favour of euthanasia is the argument from the choice of the individual, choice in this quote is subordinated, or follows from, the presence of terminal illness. Again, this can be interpreted as terminal illness being presented in the papers as the main argument in favour of euthanasia, over and above choice. 'Voluntary euthanasia discourse' features in reports on the Moor case, in an explicit and rhetorical fashion, without questioning of its applicability, in a testimony to its high legitimacy. 'Terminal illness discourse' is the discourse that seems to be used with greater ease and naturalness [sic] by the authors of those reports.

The criminal/tragic dichotomy is sometimes expressed in the press in terms of the murder/mercy contrast. The idea is the same. Murder is criminal. The tragic situation of terminal illness requires mercy. Mercy is a word that is not acceptable in expert discourse. It is, however, very frequent in newspaper accounts. In the 132 case story articles, mercy appears 81 times (including mercy kill* 71, mercy 10 [mercy or murder, doctor of mercy, mercy doctor, mercy-death doctor, angel of mercy, mercy martyr]). Mercy signifies the positive side in an opposition like the following one:

Jack Kevorkian is either an angel of mercy or an instrument of murder (Western Morning News, 15 June 1999).

The idea of mercy applies to situations that constrain the agency of the actor - to a certain extent the situation is made responsible for the action, diverting attention away from the actor. The action is perceived as the lesser evil in a bad situation. Mercy relates to the actor's appreciation of the situation, his or her compassion with another, and can but does not have to include attention to the other's wishes. Mercy is about the actor, not the one that is being killed. Mercy is not about choice and voluntariness. In that sense, the concept of mercy does not fit easily into the 'voluntary euthanasia discourse'. However, it sits quite easily with a discourse of terminal illness.

A headline from the second phase of the Moor case is quite striking:

ASSISTED SUICIDE, MERCY KILLING OR MURDER? CAN WE EVER HOPE TO AGREE ON EUTHANASIA? (Independent, 16 May 1999).

‘Assisted suicide’ is a concept that has developed out of the voluntary euthanasia movement and expert debates and their concern with voluntariness and choice, with its aim of maximising the involvement of the patient in his or her own killing and minimising the role of others; ‘mercy killing’ is used by newspapers in a discourse centering on terminal illness; and ‘murder’ relates to the legal situation in this country, where euthanasia is illegal. Here we have expert discourse, press discourse and legal discourse juxtaposed to each other, in a nutshell.

Tragic cases – the attempted killing of a man by his wife [3]

In this case, a woman tried to kill her husband who had ‘incurable dementia’. The man’s wishes, when he was still competent, are said to have been in favour of euthanasia, in general and for himself. This case is presented as a *tragic* one, treated with sympathy in the press. The tenor of the reporting is captured in this headline:

I LOVE MY HUSBAND ENOUGH TO KILL HIM (Daily Mail, 15 April 1999).

The sentiment that is expressed here is close to the one expressed through the use of the word ‘mercy’, it implies the ‘terminal illness discourse’, where terminal illness in itself is seen as the reason that justifies a drastic action like killing. Action is perceived as a reaction to a bad situation, responsibility for the outcome is deflected from the actor, the action being mediated by compassion (in the discourse of ‘mercy’), and in this case additionally by love. Love implies strong personal links, a certain merging between actor and the one being killed, that leaves the boundary between the individual who makes a choice and the individual who carries out the killing blurred. The implication is that the ‘voluntary euthanasia discourse’, a discourse of choice based on the stereotype of the independent individual, becomes inapplicable.

The sympathy for the woman that runs through the newspaper coverage of her case is based on this stereotype of love, much less on the central idea of the ‘voluntary euthanasia discourse’, choice. Even so, just as in the coverage of the Moor case, ample

room is given to quotes that promote the ‘voluntary euthanasia discourse’, like the following from Age Concern:

‘We’d prefer people to make up their own mind. It’s people’s right to choose how they live and die’ (Herald Express, 13 February 1999).

If the language of choice is being applied to a case like this one (involving a patient painted as incapable of making choices), then the meaning of the concept of choice must be seen as having been extended: a wife can legitimately be seen as choosing for her husband. Alternatively, a choice made by a person in the past is legitimately seen as a reason for the action of somebody else in the present (the living will scenario).

The meaning of choice based on the stereotype of the independent individual is seriously undermined by this kind of use of the word ‘choice’, and reveals its subordination to a ‘terminal illness discourse’. To construct an ‘absent patient’ (incompetent of decision-making in the present through dementia) as a ‘choosing patient’ is to make the ‘voluntary euthanasia discourse’ instrumental in both hiding and promoting the underlying ‘terminal illness discourse’ – hidden because of the use of buzz words such as ‘choice’, thus borrowing the legitimacy of the ‘voluntary euthanasia discourse’, at the same time as promoting it by subtly changing the meaning of the concept of ‘choice’ by extending it.

The ‘terminal illness discourse’ is based on concepts like love and mercy, which imply action in response to a bad situation, *as perceived by the actor*. Attributing ‘choice’ to somebody who cannot choose only makes visible a general truth that is obscured by the proliferation of the ‘voluntary euthanasia discourse’: choice is not an inherent power residing inside human beings. To speak of ‘individuals with a right to choose’ is often understood to mean ‘individuals natively imbued with powers of choice’ (Barnes 2000, p.149).

However, choice is always a product of context, of human beings conferring a status on each other by recognising and treating others as ‘individuals with a right to choose’. Choice does not reside in the natural makeup of human beings. This is what ‘voluntary euthanasia discourse’ does: it advocates that individuals be given the right to choose their

own lives and deaths. It does so by means of an argument that insists that individuals are born with the right to choose, that by nature they are imbued with the right to choose. The use of the language of choice in a case like this one, of a man with dementia - a condition which is otherwise seen as rendering an individual incompetent - that is: incapable of making choices - only highlights this discrepancy between reality and the representation in discourse.

The use of the discourse of 'choice' in cases of dementia points to a reluctance to address the problem of euthanasia for incompetent people in a more realistic way: people with dementia are generally seen as incapable of making valid choices regarding their lives and deaths. This implies that others must make choices for them. The question would be: on what basis should what kind of decisions regarding the lives of incompetent people be made? The consensus in this society is that people should not kill other people. The only discourse available, a discourse which seems to have gained a considerable legitimacy over the last years, with the power to challenge this consensus is the one of individual choice that allows another to kill the person who has chosen to die. If one wants to argue that demented people should be allowed to be killed, this can at present only be done by an appeal to 'choice'.

Just as in the second phase of the Moor case, the Vicky case is identified by the press as a *tragic* one, not a criminal one, deserving sympathy, not condemnation. In both cases, illness is the decisive factor that justifies sympathy over condemnation for an action that by the law in this country could be seen as criminal. Whereas this sympathy cannot be openly expressed by stating categorically that 'serious illness is enough to justify the killing of people', it can be argued that this same sentiment is expressed a lot more subtly by making extensive reference to the poor health of the patients ('Besides the Multiple Infarct Dementia, Tim has Parkinson's disease, suffers from epileptic fits and is incontinent' - Western Morning News, 31 March 1999), and the strain on the relatives ('I burst into tears and rushed out of the house and I then realised I was at the end of my tether' - Western Morning News, 31 March 1999). When addressing the issue of killing more squarely, it is done so in terms of the 'voluntary euthanasia discourse'. Any problems of applying this discourse to that particular case are being ignored.

Criminal cases

More evidence to suggest that the central notion in press discourse on euthanasia is terminal illness comes from cases that are seen by the press as *criminal*. In the coverage of the Dr Shipman case [13], who stood trial accused of having murdered several of his patients, most articles quote almost verbatim the following statement of the prosecution:

Richard Henriques, QC, prosecuting, claimed: ‘The defendant killed those 15 patients because he enjoyed doing so. There is no question in this case of euthanasia or mercy killing. None of the deceased were terminally ill. He must have found the drama of taking life to his taste’ (Daily Record, 12 October 1999).

The reference to euthanasia in this murder case obviously is made because the murderer is a doctor. When doctors kill, this can potentially be described as euthanasia. This possibility, it seems to have been felt, must be ruled out. However, the justification given here for euthanasia is terminal illness. There is no mention of choice. The most obvious thing, one would think, would be to state that the victims were killed against their will.

Two different conclusions can be drawn from this: one, that it is assumed – and doesn’t need to be stated - that euthanasia applies only to cases where patients chose to die. Or two, that the criterion that defines a killing as euthanasia, and therefore as distinct from murder, is understood to be terminal illness, regardless of the choice of the individual. The case is presented by the press as *criminal* because it involved healthy people, whereas the popular appeal of the above quote leads to the conclusion that if the people involved had been terminally ill, its presentation could well have been in terms of the *tragic*.

One case that has almost exclusively been covered in *The Times* is the ‘Backdoor Euthanasia’ case [2]. This case is slightly different from the others covered so far. The Dr Moor, the husband/wife and the Dr Shipman case all involve identifiable individuals, both victims and perpetrators. The Backdoor Euthanasia case reports a series of investigations into several hospitals in which it is alleged that practices have occurred that have led to the untimely death of a whole series of patients. *The Times* appears to

have adopted this case in the manner of a cause. As in the Shipman case, it is asserted that ‘bereaved relatives maintain that the patients were not terminally ill’ (The Times, 28 January 1999) - not that they didn’t have a wish to die.

Whereas the case is not presented as *tragic*, neither is it presented as, strictly speaking, *criminal* – maybe it would be more adequate to say the tone of the article is centred around the notion of the condemnation of *negligence*. There seems to be a reluctance to call doctors murderers; first of all it appears to be appropriate to view their actions in terms of normal professional practice or professional negligence, and only secondly, once this is ruled out in terms of, maybe, euthanasia.

There appears to be a lot of scope given by journalists to doctors to explain themselves and their actions. This leaves room for the possibility that outsiders (non-doctors) might not understand appropriately what is going on, which incidently gives a lot of power over to doctors to define and evaluate the situation⁴. The reluctance to talk about murder leads to the newspaper discussing situations that could be seen as euthanasia, involving terminal illness, even though the relevance to this case, where people are seen as not terminally ill, is not clear. It can only be assumed that the readiness to give doctors the benefit of the doubt extends so far as to wait for their own statements of whether they understood the patients as terminally ill, regardless of the patients’ choice in the matter.

This of course only makes sense if euthanasia in situations of terminal illness is seen as more excusable than in situations where patients were not terminally ill. The following quote shows that actions that can be linked to the untimely death of terminally ill people can be conceived of as positive in terms of the ‘terminal illness discourse’, but negative in terms of the ‘voluntary euthanasia discourse’:

In general, the practice of denying food and fluids to patients believed to be entering the final phase of a terminal illness is defended as ‘helping nature to take its course’. But some doctors condemn it as involuntary euthanasia (The Times, 6 January 1999).

⁴ It is argued that this is going on as well up to the levels of the High Courts – Tassano (1995) concludes that in many court cases that involve doctors, as witnesses and as accused, judges are reluctant to make a ruling and effectively follow the advice given by doctors.

This quote is unusual in respect to newspaper coverage on euthanasia in several ways.

Firstly, newspapers generally talk about 'terminal illness' in a very loose way, not making the above distinction between terminal illness as such and the final phase of a terminal illness, that is: having entered the process of dying. 'Terminal illness' in newspaper reports can be understood either in the sense of 'a terminal patient, with weeks, months or years to live' (The Times, 24 June 1999), thus blurring the boundary with 'incurable illness', 'degenerative illness' or even 'chronic condition', or in the sense of the terminal/dying phase of illness.

Secondly, the use of the word 'euthanasia' qualified by the adjective 'involuntary' is very unusual, as we have seen, and is directly reminiscent of the precision of expert discourse. Otherwise, the statement is set up in a way typical of newspaper articles, setting up an issue in terms of a contrast (see 'mercy or murder?'). Although in the light of the rest of the article, the contrast has to be seen as a rhetorical device, for the tone is wholly one of condemnation of the kind of actions referred to, the nature of it holds some clues to the more general issue of discussion in this chapter: the presence of 'voluntary euthanasia discourse' and of 'terminal illness discourse' in the press. This quote seems to give air to both.

'Involuntary euthanasia' refers to the flipside of voluntary euthanasia and choice: that of coercion. Euthanasia can only be perceived as right when the person wishes it. 'Helping nature to take its course' seems, on the face of it, to be linked to the 'terminal illness discourse', for both nature and terminal illness are conceived of as forces sharing in human agency.

Terminal illness can be seen as a subcategory of the more general concept of nature. Making reference to nature is to deflect away from the action of people, perceiving of their agency as shared with outside causes: the illness. Even though the presentation of the case by *The Times* is firmly set in the 'voluntary euthanasia discourse', by setting up this rhetorical and even polemical contrast it nevertheless gives space to that other discourse, subordinated in expert discourse but primary in newspaper discourse as a whole, which is the 'terminal illness discourse' of agency shared with other causes, of responsibility for actions deflected away from people.

'Nature' and 'terminal illness discourse'

Reference to 'nature' is made in a number of other articles about different situations. The following extract comes from the Dr Tylor case (Death of a woman with a leg ulcer [12]). Here, a doctor was accused by a nurse to have ordered her to stop the tube-feeding of an elderly, ill woman - a decision he is said to have taken in agreement with the woman's two daughters, about one of whom it is said:

The youngest daughter described how she had welcomed the decision to stop feeding her mother. 'I felt a sense of relief at the news that nature could at last take its course and she could die peacefully', she told the inquiry (Daily Mail, 27 March 1999).

As in the 'Backdoor Euthanasia' case above, the idea of nature is used to deflect agency away from the actor, leaving him to be seen to be less responsible for the action he is taking – an action that in other situations he might be held responsible for. The action is conceived of as reactive rather than proactive. Nature is conceived of as a set of rules that structure what kind of actions are possible, as well as a bedrock of facts that actions come up against. The invocation of the idea of nature asserts that nature puts limits on human intervention, and/or that nature governs what particular kinds of intervention are sensible in particular situations.

This idea of nature is socially constructed⁵. This means that whether we give a role to nature in our understandings of agency, and what role that is precisely, has differed throughout history and across cultures. Apart from the attribution of agency to humans and nature, there is also attribution of agency to spirits, gods or creators.

An understanding of the role of nature in discourses of agency in the sense of a social construction can lead to the mistaken conclusion that reference to nature is necessarily calculative, a rhetorical device invoked in support of particular arguments. Far from that, however, conceiving of nature, or God, as sharing agency with human beings, can be a very strong belief. In fact, understanding agency solely in terms of human beings must be seen as just as strong and as particular a belief. The idea of nature sharing in agency,

⁵ See Kate Soper's book 'On Nature' (1995) for a detailed discussion of this issue.

understood in terms of social construction, can function both as a rhetorical device and/or represent a strong belief.

The reference to nature by the daughter in the newspaper article can be interpreted either as her genuine appreciation of the situation, or as a rhetorical device used by her to support a particular argument (the daughter might have other reasons to want her mother dead). The important thing is to understand that her reasoning for invoking the idea of nature does not matter. Different readers might read this differently, depending on where they are coming from. The important thing is that reference to nature as sharing in agency is a discourse that carries great legitimacy, and that is why it is invoked, whether self-consciously or not self-consciously; and that is why the journalist has included this particular quote in his article.

The idea of nature also appears in an article about the grandson (case [11]) who switched off his grandmother's life support machines. He is quoted invoking nature in accounting for what he did and why:

He said: 'I felt everyone was torturing my gran for their own selfish reasons. She was being made to suffer by not being allowed a natural and peaceful death' (Evening Standard, 20 August 1999).

In the idea of a 'natural death', nature not simply is – and for that reason has to be taken account of – but in addition nature is evaluated as right and good. By implication, ignoring nature is wrong and bad. The 'natural death' has become an ideal against which the reality of particular deaths are set and appreciated.

The idea of a 'natural death' is one that the hospice movement aspires to – not to prolong life and neither to hasten death. This idea/ideal of a 'natural death' rules out euthanasia as not natural. There is no room for euthanasia in this conceptual framework. Thus euthanasia is being argued in terms of choice. The invocation of choice in the 'voluntary euthanasia discourse' sets its own conceptual framework. The 'natural death' and the 'voluntary euthanasia discourse' thus can exist side-by-side, if uneasily. The 'natural death' discourse positions the 'voluntary euthanasia discourse' of euthanasia as not being natural, but that misses the point because it is not about nature; and vice versa

the accusation that the ‘natural death’ discourse leaves no room for choice does do no harm to this discourse, because it is not about choice.

It seems from the above discussion that the argument against euthanasia rests on deflecting agency away from human beings, whereas the argument in favour of euthanasia lies agency firmly at the door of human beings. Yet, as we have seen, the ‘terminal illness discourse’ that is present in newspaper articles represents a discourse that is, if not squarely in favour of euthanasia, so at least sympathetic to euthanasia.

The central concept of this discourse is ‘terminal illness’, a (natural) force confronting human agency, and conceived of as sharing agency with human beings in certain situations. While in hospice philosophy, terminal illness and nature are constructed as impelling people to refrain from actions (towards hastening death), terminal illness and nature in ‘terminal illness discourse’ are seen as compelling people to take actions (toward hastening death). The switching off of life support can be seen as taking an action towards hastening death, or as refraining from action that interfere with natural death. Hospice usually takes the latter view, allowing some kinds of withdrawal of life support but not allowing injections of poison (or an overdose of pain-controlling drugs given with the intention of killing). But the switching off of life support and the injection of poison can also both be seen in the same terms: of helping nature to take its course – sharing agency with nature instead of giving over completely to nature. ‘Helping nature to take its course’ thus can mean any number of things: to refrain from actions or to take action.

‘To allow to die’

In press discourse on euthanasia, we find a tremendous number of words and phrases referring to actions conceived around the poles of ‘killing’ (making reference to actions causing death, seen as negative) and ‘letting die’ (referring to causes other than actions that lead to death, understood in a more positive way). The following terms and figures of speech are derived from the newspaper data:

- to kill someone
- to murder someone

- to finish someone off
- to terminate someone's life (at her request)
- to end someone's life
- to end someone's suffering
- to hasten someone's death
- to hasten someone's demise
- to speed someone's demise
- to ease someone's passage
- to allow someone to die
- to let someone die
- to let someone die with peace and dignity
- to let someone slip away
- to help someone to die
- to help someone to die a painless death
- to help someone to terminate her life
- to help someone on her way
- to help to free someone from a life of agony and pain
- to help someone on their way to a pain-free release from their painful agony and suffering
- to help someone to find peace through death
- to assist someone to kill herself
- to assist someone to go to a relaxed end
- to preside over someone's suicide
- to give nature a helping hand
- to help nature take its course
- to put someone out of their misery

'To kill' and 'to murder' puts agency squarely onto people – one responsible agent, or several people sharing agency. The majority of euphemisms, however, hint at a more shared conception of agency, deflecting responsibility away from people. 'To hasten

death' implies that death would have come anyway, no matter what the action of people – illness/nature/death is responsible at least partly. 'To let die' implies that illness/nature/death are the real agents, whereas people are only obstructions on the path of the inevitable.

'To allow to die' similarly hints at a shared agency. It can be understood in two different ways: one, not to keep somebody from dying (that is, to refrain from futile and burdensome treatment), or two, to help somebody to die (that is, to actively intervene in the dying process, to speed it up or to cause it). Hospice would use it in terms of the first meaning only, whereas it can be understood just as well in terms of the second meaning, as a euphemism for killing. While hospice sees a crucial distinction between the two meanings, it is just as possible not to see a distinction between the two at all.

There is an ambiguity in terms of its meaning inherent in the term 'to allow to die'. I will further discuss this with regard to an extract from a newspaper article on the mother/son case:

When her 12-year-old son David's condition deteriorated, hospital doctors decided it was in his best interests not to give him treatment to prolong his life. They administered the strong painkiller diamorphine to ease his suffering and allow him to die a peaceful and dignified death. But Mrs. Glass, 38, believed her son's life was worth saving and with other relatives kept him alive by refusing to let him slip into unconsciousness. Six months later, David is still alive.

[...]

While doctors agree their actions saved David they maintain it was 'an extremely cruel' thing to do and only prolonged his agony (Daily Mail, 23 April 1999).

'To allow people to die a peaceful and dignified death' with the help of painkilling drugs is something that 'hospice' (as the idea that hospices are based upon) is aiming to do. The painkilling drugs are conceived as having the potential of hastening death slightly as a side-effect to pain relief, but that the importance of pain relief justifies that small risk (see the 'double effect' in Chapter (6)). This understanding of 'allowing to die' is what doctors draw upon in their justification for their actions. Anything else would be illegal,

as the law, just like hospice, also sees a big difference between ‘not keeping someone from dying’ and ‘helping somebody to die’.

In conceiving of their actions as ‘not prolonging his life’, the doctors in effect hand responsibility for David’s death over to illness/nature/death itself, deflecting agency away from themselves and their actions. However, the mother and other relatives see things very differently – they regard the action of the doctors, the giving of diamorphine, as the cause of death if it would result. The fact that ‘six months later, David is still alive’ gives a very strong indication that the relatives were correct in their appreciation of the situation and the doctors were not. If David had died, he would have died as a result of the diamorphine.

However, the doctors are not said to agree but stick to their version of what they did. By characterising the actions of the relatives in the following terms: ‘it was an extremely cruel thing to do and only prolonged his agony’, they by implication characterise their own actions as compassionate.

The hospice movement has had tremendous influence over the last years in shaping medical practice in relation to people who are dying. The success of medical technology in keeping people alive for longer has come at the cost of a situation where at the end of their life, some people can be kept alive with an extremely reduced quality of life. This has over time led to a change in medical practice at the end of life. Whereas for a long time, doctors were automatically doing (and expected to do) everything to prolong life at all costs up until the very end of life, over the course of the 20th century this changed: at first public opinion and now slowly medical opinion is accepting that there are situations in which treatment can become both futile and burdensome, and it can be reasonable to withdraw that kind of treatment.

The hospice movement has been advocating and researching techniques of palliative care – moving away from considerations of cure to ones of care. The doctors’ rhetoric in the above article is testimony to the success of these ideas. However, with the shift away from death as the enemy that has to be kept at bay at all costs, there has come a new confusion. If death is not the enemy, then what has taken its place? What guides doctors’

decision-making at the end of life? ‘Hospice’ argues that futile and burdensome treatment is the problem, it should be withdrawn and the patient made comfortable⁶.

However, there is another argument that runs as an undercurrent through this debate: while death is not the enemy anymore, life itself in particular situations becomes conceptualised as the enemy. Life becomes the problem. Instead of treatment being seen as futile and burdensome, some kinds of life (life with pain and/or suffering – whether physical, psychosocial or existential, disabled life?) come to be seen as burdensome and/or futile.

The newspaper article above tells us that David was ‘profoundly disabled [...] throughout his life he has suffered blindness, spastic quadriplegia, cerebral palsy, epilepsy and severe learning difficulties’. Considering that David is still alive after six months, he cannot have been dying. Even though the doctors must appreciate that, they maintain that keeping him alive ‘only prolonged his agony’. This raises the question what kind of agony is being prolonged: if it is not the agony of dying, it must be the agony of living – of living a disabled life? If life is the problem, then ‘to allow to die’ appears to acquire the meaning of a euphemism for killing.

The newspaper explains the actions of the relatives in trying to keep him alive in terms of them seeing David’s life as being ‘worth saving’ (see extract above). Talking about human life in terms of its worth, especially in regard to life and death situations, is deeply worrying in its implications, but very normal in everyday discourse. Its normality is plain in the unselfconscious use of it in the context of this article. Appreciation of the relative worth of human beings is exercised constantly in newspapers, through the making of judgements of social value and letting those influence the evaluation of their view of particular situations.

A big part of an article on the case of the grandson (case [11]) switching off the life support of his grandmother is devoted to determining his social status, which accordingly must be seen as having a bearing on the evaluation of his case:

⁶ See for example Saunders (1979)

Shara Karapetian, a ‘brilliant’ 23-year-old university graduate...

[...]

He [the judge] described Karapetian as an outstanding young man. He had already obtained a masters degree in engineering from Imperial College London and he was now studying for a master of science degree which will lead to a doctorate (Evening Standard, 20 August 1999).

Considering that the newspaper relates what the judge has said, it appears that newspapers shares their interest in the social status of the accused with judges and probably others. Neither the media nor the legal system are independent of considerations of social status. This has to be taken into account when looking at the context in which ‘killing’ and ‘letting die’ are being articulated. The presentation of the people involved in terms of their status is implicated in all portrayals of agency. Although this point is a minor one in relation to the argument presented in this chapter, it is one we always have to bear in mind.

Discussion

In this chapter I have explored press discourse on euthanasia, starting out with the finding that it is notably distinct from expert discourse, at the same time as incorporating some of its notions. I will now attempt a summary of my conclusions.

Expert discourse on euthanasia is largely conducted around the organising principles of choice and coercion. This is what I have been referring to as the ‘voluntary euthanasia discourse’ – talking about euthanasia in terms of it being voluntary or involuntary. This discourse rests on the stereotype of the independent individual that informs the basic prejudice that individually chosen actions are good (choice as absence is positive), and that social influence is bad (coercion by others as its negative opposite).

Agency is conceived of as resting exclusively in human beings, as enshrined in the institution of responsible action, that aims to establish which person/persons to hold responsible for a particular outcome. This view of agency is shared by the law which holds that the human agent ‘responsible for something must be its cause and yet not be

acting as the effect of some further cause' (Barnes 2000, p.9), the law is thus aiming to establish which human action has been the ultimate cause of a particular outcome, reducing complexity as far as possible. The argument in favour of euthanasia thus rests on the positive evaluation of choice residing in independent individuals, that can translate into an argument against euthanasia by pointing to the negative influence that others can have on the choice of the individual, including overriding it (coercion). While coercion can be seen by proponents of euthanasia as a problem that is manageable, opponents to euthanasia argue that it is not.

There is another view of agency in another argument against euthanasia: one that places agency beyond human beings, that holds that in regard to death and dying, agency properly belongs not to human beings but to God or nature. It is a fundamentalist view that argues categorically against killing in every form and situation. While the 'voluntary euthanasia discourse' to a certain extent gets endorsed in the press (it represents what I will call a *minor discourse*), the fundamentalist argument against euthanasia, sometimes mixed up with the question of coercion in the presentation of the argument against euthanasia, gets reported as the moral element in the euthanasia debate. As such, it is quite marginal to press discourse itself.

That the press discourse has its own morality will become clear once we have looked at the structure of it. While the 'voluntary euthanasia discourse' has a presence in newspaper coverage, when looking at case stories, I have identified the main organising contrast to be the one between 'tragic' cases and 'criminal' cases. This is what I have previously called the 'terminal illness discourse', representing the major discourse in press reports on euthanasia cases.

Whether a case is presented as tragic, in terms of mercy, or as criminal, in terms of evil, rests on the presence or absence of the central notion of terminal illness (the words choice/choose/chosen appear 36 times in 132 articles, the terms terminal illness/terminally ill appear 95 times, that is almost three times as often, which might give another indication of what newspapers concentrate upon). Criminal cases are presented much in the same terms as they would be understood by the law (through the institution of responsible action).

Tragic cases, however, that would mainly be understood by the law as criminal, too, are treated completely differently by the press. This difference can be understood in terms of a different view of agency. In effect, in those cases terminal illness is perceived as sharing in agency. The institution of responsible action gets complicated by adding the institution of causal connection. Terminal illness is seen, at least partly, as the cause of the death of an individual, deflecting responsibility away from whatever actions human beings have taken.

Reference to illness, just like reference to nature, allows for a more complex appraisal of situations in which agency is perceived to lie not solely with human beings – any human beings, quite apart from the individual/others pattern of the choice/coercion contrast. In any case of euthanasia, the law would look for the one person responsible for final action that led to death⁷. Press discourse, which incidentally claims that it represents common-sense, is putting forward a view of euthanasia cases where - as long as terminal illness is involved – a combination of causes will have led to a particular outcome.

Press discourse, which presents euthanasia as a legal-moral problem, conceives of its own morality in terms of a representation of common sense, at the same time as it is mindful of the present legal situation and the principles of law. In cases where the two clash – that is in the cases seen by the press as tragic and by the law as criminal – it sees its role as questioning the sense of the law, which after all figures as a codification of everyday understandings (if more in image than in reality).

The fact that the press to some extent endorses the ‘voluntary euthanasia discourse’ but not the fundamentalist argument against euthanasia is strikingly obvious in the feature articles in reaction to the end of the Dr Moor trial (see Chapter (6)). Three articles argue for the legalisation of euthanasia. Four argue against it. Nine are discussing the merits of both sides. The three articles in favour of legalisation are written by journalists, arguing their case in terms of choice – the ‘voluntary euthanasia discourse’, and common sense – their own discourse around terminal illness. Three out of the four articles against

⁷ In Spain, euthanasia is being intensely discussed in the wake of its legalisation in the Netherlands. Reference is made to the case of Ramon Sampederro, who had lived as a paraplegic for many years and finally decided he didn't want to live like that any more. He got a large number of friends to carry out one small action each that in the end led to his death. The Spanish courts, that were looking for the person who committed the crime, who performed the ultimate action that killed Sampano, could not prosecute because all the people came forward and said ‘it was me’ (see Guerra 1999).

euthanasia are not written by journalists but by medical professionals, one by a nurse and two by hospice doctors. This deference to ‘experts’ points to an acknowledgement that it must be they who know best – but it can also be read as evidence for the fact that their particular view (categorically against killing) is at odds with the general tenor of press discourse on euthanasia. If this is the case, it further strengthens the argument I have made in this chapter.

Euthanasia at present is being discussed in many countries. Reports in British newspapers are not just about British but also about foreign cases. The case of the French nurse [8] killing terminally ill patients led a paper to write that ‘France is divided between strong Roman Catholic hostility to euthanasia and mounting liberal pressure in favour of decriminalisation’ (The Times, 16 June 1999). The contrast here is set up between Catholicism and liberalism. It is when we look at what they stand for in terms of agency we can derive from this statement a more general argument, with applicability also to Britain.

Catholicism places agency in the last instance beyond human beings – God is the ultimate agent. Liberalism imagines agency to reside in human beings, or more precisely, in individuals (we are talking caricatures, of course, as both theology and liberal theory have much more differentiated things to say on the matter). Liberalism and the stereotype of the independent individual are the central notions around which most Western societies are organised at present. The pressures to legalise euthanasia are coming out of those societies. The arguments in favour of euthanasia are sharing in the same discourses, as do to some extent the arguments against, as long as they are presented in terms of coercion. An argument that categorically stands against euthanasia on the basis of the belief that death and dying is and should always be beyond human agency is utterly alien in a system that conceives of agency as solely or necessarily, if only partly, human. That explains its marginality in press discourse which endorses the principles of liberalism.

Still, we have seen that press discourse has a different view of agency in the case of euthanasia than the strictly liberal one. Press discourse allows for a conception of agency as shared with entities that are ‘not human’ – meaning concepts that have become objectified into reified forces, for example God or nature, which implies that they are conceptualised (by humans) as having agency independent of human beings. Terminal

illness is such an agent, which in the view of the press has to be taken into account for a realistic appraisal of euthanasia cases. This is not to say that the press categorically argues in favour of euthanasia in each and every case of terminal illness. The partial appreciation of the minor discourse of ‘voluntary euthanasia’ in the press points to the conclusion that human agency, understood in terms of choice and coercion, is by no means something the press is indifferent to. Human agency is fundamental for the press, in so far as it endorses liberal discourse. However, in the view of the press, human agency can be supplemented by an appreciation of non-human agents sharing in human agency. Human agency may be the fundamental ingredient, but non-human agency is an additional one. This leaves room for discussions of illness, nature, maybe even God, as long as agency is not being attributed exclusively to any one of them. It is the exclusiveness of the attribution of agency to non-human agents (God or nature) that renders the fundamentalist argument against euthanasia, in each and every single case and without exception, alien and unacceptable to normal press discourse.

Conclusion

The press evaluates and presents euthanasia cases as ‘tragic’ or ‘criminal’. It makes this distinction on the basis of the attribution of agency to different elements regarded as making up a particular situation.

Where agency is attributed to humans only, ‘killing’ – humans causing death – is evaluated as evil, and the case as ‘criminal’. In cases where terminal illness is seen to share in the make-up of a situation, agency becomes diffused and responsibility for death somewhat diverged away from human beings – their actions come to be seen in terms of ‘letting die’, and the case as ‘tragic’.

Also, in a sense, agency is displaced away from human beings onto objectified forces (God, nature), that, conceptualised as independent of human beings, can force humans to act in a particular way. The precise nature of the actions carried out by humans, whether they cause death – ‘kill’ – or whether they don’t prevent death from happening, becomes irrelevant.

Terminal illness comes to be regarded as partly responsible for death, and can thus come to justify killing, whereby killing has lost some of the negative connotations it has in cases where humans are seen as completely responsible for death. In criminal cases, killing is bad, in tragic cases, less so. The presence of terminal illness leads the press away from a generalised taboo on killing, to a more differentiated evaluation of killing in context – first of all regardless of the preferences of the ill individuals involved.

The discourse of ‘voluntary euthanasia’ and its central principle of choice nevertheless has a presence in the presentation of euthanasia cases in the press, suggesting that euthanasia cases where both terminal illness and choice are present are regarded as the most legitimate ones.

There is no room in press coverage of euthanasia for the discourse that denies that humans (should) have any agency at all with regard to death, whether in the form of actions leading to or causing death, and whether the situations involve terminal illness or not, this position being justified with a complete displacement of agency onto non-human entities like God or nature.

Postscript to Chapter (7)

Reflections on a television programme:

'Mercy' - part of the BBC1 Series **Murder in Mind** (Sunday, 20 May 2001)

I can now show how the categories exposed in Chapter (7) can be applied in the analysis of new material. The hour-long murder mystery 'Mercy' (in the BBC1 series 'Murder in Mind') constitutes a wonderful illustration of the distinction routinely made in the media between tragic and criminal cases. The Guardian TV guide advertises the program as follows:

'A gentle country doctor reluctantly assists in the suicide of his terminally ill wife. To the police he is a criminal, to the local community a loving husband who allowed his partner a dignified death – fuelling a public debate on euthanasia. But is there more to the case than meets the eye?' (The Guardian, 19.May 2001).

The program starts with the scene where the wife takes an overdose of medication, with her husband looking on. There is a slightly sinister feel to the whole set-up. The next thing we see is that the dead woman is taken away in the ambulance, the doctor questioned about the incident by the police who suspect murder, especially as the doctor is the sole inheritor of his wife's considerable assets – house and money.

After that, the doctor comes onto a television program, where in dialogue with a journalist in front of a live audience he recounts the whole story, which we see in flashbacks to the past – switching between studio (present) and realistic scenes (past). The more the doctor explains himself, the more we are taken in by his story. We see him as a caring doctor in a small community as well as a caring if not passionate husband to his wife. We see him declare: 'I disapprove of euthanasia'. We see the woman developing headaches and dizzy spells, slowly becoming aware of her condition, confirmed by a specialist consultant – a rare brain-deteriorating disease that leads to a particularly horrifying death. We witness how she starts thinking about killing herself and

finally deciding to do it. We see how the doctor refuses to help her, but then reluctantly gives her a substantial amount of painkiller and answers her question when she asks: 'How much do I take?'. Again, we see the scene from the very beginning, where she takes the overdose, filmed from a slightly different angle, hearing a couple of sentences spoken between them that we didn't see at the beginning. In the light of the doctor's story, the scene takes on a much less sinister feel than initially – at this point, the journalist mentions that the press has come down very heavily on the side of the doctor, generally expressing support for him – reading out a couple of headlines from newspaper articles. The audience in the studio is asked whether they approve of the doctor's actions or not: a brief show of hands reveals roughly 80% to approve (the same number routinely mentioned in the press referring to approval of euthanasia in the population). The support of the doctor in his village is shown to be almost universal, a couple of people come up on a screen in the studio speaking their views. The nurse in the doctor's surgery says: 'I'm not against euthanasia, I think people should have the choice'. The only person not universally in favour of what the doctor did is the local vicar, but even he concedes that he believes that the doctor believed he was doing the right thing at the time – at the same time as he stresses that he believes the doctor did wrong in assisting a suicide. At this point, the police enter the studio. They take the doctor away. At the police station, he is told that he is being arrested for murder. The policeman tells him of new evidence that shows that the doctor has been slowly poisoning his wife – explaining the headaches and dizzy spells. He wanted to get rid of her because he was in love with a neighbour, but couldn't just leave because everything belonged to his wife, he owned nothing. The neighbour played the role of the consultant neurologist telling the wife of her disease and the horrific consequences. The doctor planted the idea of suicide in her mind, at the same time as he seemed to discourage her from doing it. The doctor confesses to all the charges, reflecting how at the time he was thinking he was committing the perfect murder where the victim does it for you. In the last scene, we see the journalist alone in the studio, looking at a screen where the doctor is seen telling his lies: 'If you love somebody so much...'. At this point, the journalist shakes his head, throws his jacket over his shoulder and heads for the door. The end.

This plot is very illuminating of current popular representations of euthanasia as exposed in Chapter (7) – indeed, the way it puts them to play is one of the reasons why it is so entertaining. The whole story rests on the opposition mercy/murder (tragic/criminal) as discussed in Chapter (7). In an exercise of intertextuality, this fictional program refers to representations of attitudes of the population as they are presented in real newspapers. It recreates the outcome of real surveys (80% in favour of euthanasia) in the show of hands of the fictional studio audience. It presents the press as having a positive and understanding attitude in their reporting of euthanasia cases, something that my analysis of real newspapers clearly shows. The realism of this fictional plot aims to take the viewer in, and if it is true that a large percentage of the population is indeed in favour of euthanasia, as the real surveys suggest, it is likely that the viewer finds the doctor's story more convincing than the murder suspicions of the police and the moral squeamishness of the vicar. In the press, the law is seen as not in keeping with the attitudes of the population, and there is pressure to change it. The church is seen as a moral guardian that is rooted in another time, not having caught up yet with life in a liberal state. The spotlight is on the tragedy of terminal illness, as well as the individual and his or her right to make their own choices. It is because tragic stories are given a lot of credibility in the real press, that it comes as a surprise that in this case the tragic story hides a criminal act - that 'truth' is on the side of the law and the church, both of which are resurrected as being of some use after all. In a way, this program, which is part of the media, makes ironic use of the positive – and, in the light of this program, slightly naïve – position taken in much of the media in general in relation to euthanasia. If there was a moral intended to this story, it might be that in their zeal to present the tragedy of euthanasia in terms of good people only wanting the best for each other, the media neglect the other possibility of people wanting to be rid of others, be rid of responsibility, to indulge greed or indifference – and how the readiness to believe the story of the good husband and the good doctor might make us blind to bad acts.

Another striking feature of this story: the husband that is at the same time a doctor, or the doctor that is at the same time the husband. In many of the cases that get reported in newspapers – the ones that I have looked at – doctors and relatives play different roles. The doctor has power in virtue of his or her access to drugs that can kill, and is usually to

be found in a professional, detached relationship with the patient. He or she can act at the service of the patient, patronising the patient, or even act by overriding the patient's wishes. The relatives either are deeply involved with the patient through bonds of love and only want the best for the patient, or else they are portrayed as greedy individuals out for their own satisfaction, aiming to either get rid of a burdensome dependent or to come into inheritance in the form of money or other assets. In this story, both figures merge: the doctor with access to deadly drugs is also the greedy relative. This is curious and deserves some elaboration. Why was it important in this story that the husband was also a doctor? Couldn't it have worked just as well if the husband had been a teacher? It seems that there is a basic assumption involved that also underlies the current debate on euthanasia: the portrayal of euthanasia as a medical issue. It seems to me that the fact that doctors are able to easily and legally get hold of deadly drugs translates into the assumption that drugs are the only acceptable means to kill oneself. Other means, that people other than doctors have access to, are ruled out completely. The instructions given in the book 'Final Exit' by Humphry (1991) on how to use a plastic bag, for example, are seen as grisly, horrific and unacceptable, whereas drugs are seen as – what? Clean, efficient, not messy, success guaranteed (although this might not be what happens in reality) – in one word, acceptable. The weight of the decision: 'I will kill myself, and I'm prepared to do anything it takes to achieve that aim' has become diluted to: 'I don't want to kill myself, really, but this stupid illness that nobody seems to be able to do anything about forces me to take this step, if I don't want to end up as a dribbling idiot that is, which of course I don't, so can we at least do it as painlessly and dignified as possible, please'... The other thing is that those deadly drugs are used in palliative care, with the explicit aim of controlling pain. Death after an overdose can always be attributed to the patient having made a mistake in the dosage, whereas suffocation by plastic bag or pillow can never be accidental and always involves somebody else. In addition to the *efficiency*, it is the *ambivalence* of the drugs that doctors have access to that make them so important in discussions of euthanasia. Whereas there are doctors that kill just because they can (for example, Dr. Shipman), this is a relatively rare scenario. It is generally close, personal relationships that engender passions like love and hate that lead a person to kill. The husband in this murder mystery combines the role of the doctor with the easy access to

drugs which seems almost essential to modern euthanasia cases, and the passionate hatred of a close personal, if unwanted relationship – that can always disguise itself as love.

To sum up: the program ‘Mercy’ reaffirms my finding that the media represent euthanasia in terms of the opposition mercy/murder, or tragic/criminal. In an exercise of intertextuality, the program makes reference to features of euthanasia coverage in the news media, like the fact that newspaper coverage of particular cases is usually sympathetic, and that generally a large proportion of the population is portrayed as being in favour of euthanasia. The program thus makes ironic use of the categories that characterise the contemporary debate on euthanasia, in the media and beyond.

Chapter (8) – British newspapers and other countries

Introduction

So far, I have looked at euthanasia as the topic of a nationally undefined ‘expert discourse’ and of a media discourse of British newspapers. This chapter will address a dimension of the debate – of both its content and context – that has until now been left unexplored: the construction and the ‘reality’ of the euthanasia debate as not just a British phenomenon. My main set of data will be the same one as in the last chapters, which means I will mainly look at the construction of the international dimension in British newspaper articles on euthanasia, but in addition I think it to be important to point to what I call above the ‘reality’ of the euthanasia debate as international: the fact that it is being discussed in other countries, too. I will make some references to German newspaper articles on euthanasia, not claiming to make a proper comparison with the British coverage but mainly to point to some similarities and differences in the approaches to covering the subject (which could properly be explored in some further research project).

The theoretical framework with which I will think through those issues is the globalisation debate in sociology. Discussion of globalisation has proliferated in the social sciences for the last decade; some call it an industry or even a ‘paradigm’ (Urry 2001). I won’t go into the contested issues around it in any detail, I will merely use the basic assumption that in the world today, the ‘global’ - eclipsing the nation - has become the main reference point not just in economic life, but also in the cultural and perceptual life of individual people, having direct repercussions for the local. The mass media is seen as an important source promoting global consciousness in people (Urry, see below). While I do not want to contradict these findings, I will point out that the British newspapers coverage of euthanasia, while making reference to other countries, is not in any way concerned with presenting the issue as a global phenomenon.

Media discourse on euthanasia – beyond the national, towards the global?

My analysis of the international/transnational/global dimension of media discourse on euthanasia consists of three parts: first, a discussion of the different cases (British and foreign) that have made it into the press; second, a discussion of reference to foreign situations as a rhetorical feature of the British discussion on euthanasia in the press; and thirdly, a brief aside on the similarities and differences between British newspaper coverage of euthanasia and that in other countries, using the example of Germany.

1. British and foreign cases

Out of my data set of 13 cases of euthanasia reported in British newspapers during one year in 1998/99, 10 are British and 3 are foreign: there is one American, one Austrian and one French case. The British cases that have given rise to many articles appear both in the national newspapers (The Times, The Independent, The Guardian) as well as in the local papers (for example, the case of the wife trying to kill her husband took place in Devon, and is covered extensively by the Herald Express from Torquay; Dr. Moor came from Northumberland and was tried by Newcastle Crown Court, and his case is covered in greater detail by the Evening Chronicle from Newcastle). Some of the smaller cases may only appear in local papers, like the case of the grandson which took place in London and was only reported in the Evening Standard from London. There clearly is a difference between local interest and national interest. This national interest is constructed by the appearance of a case in a national newspaper. The existence of a national interest is thus contingent on the structure of the newspaper market, divided into local and national. This might be an obvious point but an important one for the discussion of the global. As long as national newspapers generate national interest, the conceptual category of the national will not disappear¹. Ulrich Beck says, 'there is, for example, no real European newspaper. Nor is there a European television programme worthy of the name (that is,

¹ See Anderson (1983) on the role that print-capitalism played in the historical constitution of nations as imagined communities. The analysis presented here suggests that newspapers continue to play that role in an ongoing process. See also Brookes (1999) who in an article on the BSE crisis, newspapers and national identity makes that same point that national identities are not just imagined once, but are continually being reinvented.

which grips its European audience to such an extent that national programmes slip down the table of viewing figures)' (Beck 2000. P.157)². Neither are there any real worldwide newspapers. The largest category on the newspaper market is the national.

The category of the national gets promoted further in the way foreign cases are reported. In the cases of the American Dr. Kevorkian and the French nurse, both are treated like symbols that crystallise not just the whole euthanasia debate in their respective countries, but much more than that they both stand for the societies they come from; they are understood in terms of what is assumed to be known about those societies and, being constructed as such, they in turn reconfirm our knowledge about those countries. I will give some examples from the Kevorkian case.

First of all, these quotes connect the man and the country:

'America's "Dr Death"' (Independent, 26 March 1999),

'Dr. Jack Kevorkian, America's self-appointed angel of death' (Sunday Telegraph, 21 March 1999).

Whereas these phrases could be seen as simply placing the man on the map, the following ones explicitly built on assumed common knowledge between newspaper writer and readers about American society:

'THE AMERICAN WAY OF DEATH' (headline, Independent, 16 March 1999),

'Kevorkian's story could only happen in America' (Bath Chronicle, 14 June 1999),

² On the 12th July 2001, the German weekly paper 'Die Zeit' ran an article on the 'Financial Times Europe', characterising that newspaper, in the subheading of the article, as being the only daily newspaper to create a European public ('die einzige Tageszeitung, die eine europäische Öffentlichkeit herstellt'). In the body of the text, however, this evaluation is being relativised, noting that the 'FT Europe' is directed at and recognised only by a particular group of people ('eine [...] europäisch, ja global denkende Klasse habe sich längst gebildet, 'Leute mit Geld, die es nicht verlieren wollen oder noch mehr davon haben wollen' – in english, a group of people whose thinking is european and global, people with money which they don't want to loose or wanting more of it). It is also added that maybe, what the 'FT Europe' needs is a pan-european daily newspaper as competition ('eine paneuropäische Tageszeitung'), an as yet non-existent entity.

‘A lot of people he “helped” were nowhere near the end of their lives, and it may say more about American society that they consider themselves better off dead’ (Western Morning News, 15 June 1999).

All of those quotes make reference to the particularity of American society, they take for granted cultural knowledge about the ‘American way of life’ and more generally the social conditions prevailing in that country. ‘It could only happen there’ reaffirms what we already know about this society. On a very basic level it also reaffirms that there is a category of America, that it makes sense to talk about nations and societies – and that as conceptual categories they are still very strong in the media and are scarcely in the process of being replaced by a category of the global.

Another interesting point is that both the case of the French nurse and the Kervorkian case are presented in terms of the relevance for the particular country they take place in, there is no suggestion that those cases could have some relevance for Britain:

‘A French nurse who has admitted to killing terminally ill patients will today be charged with murder in a case that has sparked fierce nationwide debate over euthanasia. [...] France is divided between strong Roman Catholic hostility to euthanasia and mounting liberal pressure in favour of decriminalisation’ (The Times, 16 June 1999).

The Kevorkian case (which has attracted a lot more coverage than the French nurse case, for reasons I will not go into here) is treated in a descriptive way, describing what has been said in court, what is the background of the case. The articles describe and to a certain extent explain the case in terms of American society and in terms of the individual’s biography. At no point do they suggest that euthanasia is a problem for Britain or other countries, too, or that because of that the cases might have some relevance beyond the particular country in which it took place. Euthanasia here is presented as a particular problem for a particular society.

The third foreign case, the case of an Austrian doctor involved in euthanasia killings during the Nazi regime, is presented as particular in an even more obvious way. One could conjecture that the imagined nations of America and France are quite close to the British newspaper writer and reader, and the shared images of what they

are like are quite detailed, which means that knowledge of those images can be presupposed and made reference to in communication, without necessarily spelling them out – which can be seen above in the examples from the Kevorkian case. The concept of Austria on the other hand is largely a blank space devoid of images that have to be filled, or a space of confused and inaccurate assumptions. One newspaper article on the Austrian case starts as follows:

‘Austria is not a backward country. Opera is subsidised by the state and the streets are safe to walk at night. Parks are well maintained and public transport is cheap and efficient’ (Independent, 30 April 1999).

It seems as if in the case of America and France, a shared image of the countries is presupposed, while in the case of Austria, a common image has to first of all be constructed in the text. In addition, the American and the French case refer to euthanasia in the present, the Austrian case refers to euthanasia in the past, specifically the Nazi past³, which increases its imagined particularity even further.

It could be argued that the foreign euthanasia cases are being reported in the British newspapers in the first place because some kind of relevance to the British readership is being perceived, however the fact is that in the way they are reported, there is no suggestion that those cases have any relevance for Britain at all – they are firmly linked with the countries in which the events took place. In the British cases, we have seen that some are only being reported at the local level, other local cases make it into the national news. The Dr. Moor case in particular is constructed as having relevance at the national level – it has sparked a large number of articles discussing the implications of the case for British society, the meaning of it for British society, the particularly British social conditions in which that case occurred in the first place. On the one hand, it is not surprising that the discussion of euthanasia should be presented as particular to a certain country, as presently the main point of discussion centres around the legalisation or legal regulation of the practice, and the

³ At this point, a reference to what can be called the ‘Nazi argument’ in the euthanasia debate suggests itself. The ‘Nazi argument’ is the argument against euthanasia in the present which is based on our knowledge of how it was practiced under the Nazi regime. It argues that the legalisation of euthanasia would inevitably lead to a society with Nazi traits: brutal, based on fear and suspicion. This argument is virtually absent in British newspaper discourse on euthanasia, suggesting that in Britain, the Nazi past is not seen as a common heritage of humankind (imagining the global...) with lessons for British

system of law is still to a large extent set within the framework of individual nations. On the other hand, however, it is interesting to point out how taken for granted the concept of the nation is still today in the era of globalisation, a fact that may be overlooked by theorists of the global.

2. Reference to foreign situations as a rhetorical feature of the British discussion on euthanasia in the press

I will now move on to look in some more detail at the 10 British cases reported in the papers. Whereas there is no reference being made to Britain in the articles on the foreign cases, the newspaper texts on the British cases do make reference to other countries. The country that is evoked mostly is the Netherlands, for the obvious reason that for over 25 years it had been moving steadily towards the legalisation of euthanasia. At the time of the articles in my sample (1998/99), euthanasia had not yet been legalised in the Netherlands but had been decriminalised for some time – meaning that doctors could practice euthanasia without being prosecuted provided that they followed a certain set of rules of due care, including notification to the coroner. At the beginning of the 1990s, the Dutch government set up a commission which carried out a national survey (called the Remmelink survey) on the nature and incidence of euthanasia in the Netherlands, published in 1991, followed by a second study in 1995 (Maas et al, 1991 and 1996). No other country has a similar history of engagement with the subject or such an extensive knowledge of actual practice as has the Netherlands. Consequently, the Netherlands is an obvious place of reference for anybody who wants to make claims about euthanasia.

Let us look at how the British newspapers treat the Dutch situation. The following quotes all come from articles on the Moor case, as that was the case that gave rise to discussion and comment, in addition to the simple reporting in most of the other cases.

Nine articles mention ‘Holland’ or ‘Dutch’ or ‘Netherlands’ 21 times altogether. 4 articles mentioned either of those terms only once, 1 mentions it twice, 1 three times, and 2 six times. Analysing the quotes, one notes a curious mixture of the informative and the polemical. The recurring story is that euthanasia has been decriminalised in

society today. Rather, from the point of view of Britain the Nazi past is the past of particular countries: Germany, Austria – and only relevant to them.

Holland, that the Dutch government is currently considering legalisation of the practice which would make it the only country in the world to do so, that the practice is governed by strict rules, but that a survey (referring to the Remmelink report, without naming it) has shown that the rules were breached and safeguards were inadequate. All the articles tell either this whole story or a part of it. This extract from the Birmingham Post is typical:

‘In Holland, voluntary euthanasia has been decriminalised since 1984 - but there are strict rules and mercy killings can only be carried out at the patient's "explicit request" and when there is "intolerable suffering without prospect of improvement".

However, a study published earlier this year showed that the doctors in Holland were repeatedly breaching rules and that the safeguards in place were not adequate.

Campaigners against euthanasia claimed the study showed that euthanasia could never safely be regulated.

The Dutch parliament is currently considering legislation to legalise euthanasia - which would make it the only country in the world to allow the practice.

Around 3,000 people a year in Holland die as a result of voluntary euthanasia, according to latest figures’ (Birmingham Post, 12 May 1999).

The Remmelink survey referred to implicitly in the newspapers has given rise to several interpretations in expert discussions (see Chapter (4)). It is thus interesting to see that all the newspapers use it as a marker that shows how bad the situation is in the Netherlands. Looking carefully at the quote above, we can see what has happened to that particular interpretation of the report - it has become an argument on the side of campaigners against the legalisation of euthanasia:

‘Campaigners against euthanasia claimed the study showed that euthanasia could never safely be regulated’ (see above).

Are we talking about Dutch or British campaigners? Is it meant that euthanasia could never be safely regulated in the Netherlands or in Britain? It can be assumed that campaigners against euthanasia are against euthanasia regardless of the country in

which it takes place, and that ‘never’ means ‘never anywhere’. However, to make such a universal claim in a British newspaper ultimately means making a claim for Britain.

This leads me to the rhetorical function of making reference to the Dutch situation in the discussion of British euthanasia cases, whereas we have seen that in the reporting of foreign cases in British newspapers, no link is made between ‘them’ and ‘us’. The American, the French and the Austrian cases are particularised and thus distanced, by reference to the particularity of the social context and the national laws. The invocation of the Dutch situation, however, is very different. On the one hand, the Netherlands have to be particularised – after all, it has its own social and legal context as a nation, too – but only to ignore this particularity and stress the similarity or even equality between their situation and ours. In the event, the whole complexity and particularity of the Dutch situation has been monopolised by an anti-euthanasia rhetoric that holds that we know what happens in Holland, and that this tells us immediately what would happen here or anywhere. Particularity has become universalised. America and France have nothing to do with us, but Holland has everything to do with us. Holland has become the negative image of what Britain would become if euthanasia would be legalised in this country. The grisly picture is fleshed out by gory details and polemics:

‘In Holland, voluntary euthanasia has careered out of control so badly that the Dutch now carry cards refusing euthanasia because they are frightened doctors will kill them prematurely if they fall ill’ (Sunday Times, 16 May 1999).

‘In Holland, more than 10,000 people have started carrying anti-euthanasia “passports” because they are frightened of being killed by over-enthusiastic doctors’ (Northern Echo, 12 May 1999).

‘Nurses in the Netherlands who take part in a mercy killing are allowed to take the rest of the day off. Perhaps taking in a movie or a quick trip to the shops is enough to get over what you have done’ (Sunday Herald, 16 May 1999).

In effect we can say that the particularity and complexity the Dutch situation has been reduced to one anti-euthanasia argument for the British debate.

The Netherlands is not the only country invoked in the articles. At the time (1998/99), the USA, particularly Oregon, as well as Australia, particularly the Northern Territory, were referred to, as in both there had been attempts and partial successes in introducing legalisation of assisted suicide and euthanasia respectively, as well as Switzerland, where assisted suicide is not illegal. However, in comparison to reference to the Dutch situation, reference to the other countries was usually in one sentence, sticking to the informative:

‘United States: Dr Jack Kevorkian, known as ‘Dr Death’, who filmed himself giving a lethal injection to a dying man, was recently convicted of second degree murder. Doctor-assisted suicide has also been legal in one US state, Oregon, since 1997. Legislation is in the pipeline in California. In all other states it is illegal. [...]

Australia: Euthanasia was legalised in the Northern Territory in 1995, but the law was overturned by the supreme court in 1997. Attempts to reinstate it have been unsuccessful. In all other states it is illegal.

Switzerland: Doctor-assisted suicide has been legal since the late 1970s’ (Guardian, 12 May 1999).

The mere listing of other countries suggests that euthanasia is not just a British problem. Again, although particular countries are mentioned, their particularities are erased. It is suggested that something is happening in them that can be categorised under the heading of ‘euthanasia’ or ‘assisted suicide’. The problem of euthanasia thus gets some sort of international dimension, although I would hesitate to call it global.

As noted above, the quotes so far come from articles on the Moor case. The Moor case was presented as a euthanasia case by the press. The category of euthanasia was invoked to encompass that particular case (which was by no means universally seen as a case of euthanasia), and once the category and not the particularity of the Moor case became the issue, the category was discussed: euthanasia, including euthanasia in other countries. One can see a contrast with the ‘Backdoor euthanasia’ case, which concerned the alleged illegitimate withdrawal of artificial nutrition and hydration. Unlike the Moor case, the ‘Backdoor euthanasia’ case does not centre around one particular person or incident, but several. Several hospitals ‘around Britain’

(Birmingham Post, 6 January 1999) are said to be involved. Even though the newspaper articles categorise these occurrences under the heading of euthanasia, there is no discussion of other countries in any of the articles. The contrast to other articles on euthanasia is striking: in the Moor case, understood as a euthanasia case, there is reference to an international dimension of the general problem of euthanasia. In this case, also presented as euthanasia, there is no reference at all to other countries, suggesting that this type of euthanasia is a particularly British phenomenon. The press thus seems to recognise different types of euthanasia – one that is a general problem, also affecting other countries, and one that is a particular problem, unique to the British case. It is not the case that the latter does not happen in other countries – indeed Luest 2001 (as yet unpublished) shows that similar things (careless and/or deliberate starvation or dehydration of elderly people who are dying as a result – albeit this report is about nursing homes rather than hospitals) are happening in Germany; the fact is that the British press constructs one type of euthanasia as unique to Britain and another as general and international.

We have seen that, while articles about euthanasia in other countries in the British press do not make an explicit link between those foreign and the British case, the articles about euthanasia in Britain look towards other countries and their practices with respect to euthanasia. Reference to other countries is made in those articles to support a particular argument – and given this strategy appears to be a routine strategy, it can be assumed that it also tells us something when this (the reference to other countries) is absent.

3. Similarities and differences between British newspaper coverage on euthanasia and those in other countries, in the example of Germany.

In this section, a less formally drawn sample of German newspaper articles (involving cuttings from DIE ZEIT, Frankfurter Rundschau, Wendlinger Zeitung - a weekly national, a daily national and a daily local paper – from the time just after the legalisation of euthanasia in the Netherlands in April 2001) will be compared to the British coverage analysed so far.

In one respect, newspaper coverage of euthanasia seems to be very similar in both countries. The concern of newspapers to inform does lead to presentations of what constitutes euthanasia, what different groups think about it, and commentaries by

journalists weighing up the right and wrongs of euthanasia as well as the rights and wrongs and practicalities of the legalisation of euthanasia in the respective countries. Even the layout is similar – in response to the legalisation in the Netherlands in April 2001 both the Guardian and the Wendlinger Zeitung in a box separate from the main articles listed a number of countries and their practices regarding euthanasia. In the case of the Guardian, the list of countries referred to had changed and diversified considerably since 1999 (see the 1999 article above: Britain, Netherlands, America, Australia, Switzerland). The 2001 list includes: Belgium, Sweden, Denmark, France, Britain, Germany, America, Australia, China (Guardian, 11 April 2001). The German paper in 2001 lists Denmark, Sweden, France, Britain, Belgium and Switzerland (Wendlinger Zeitung, 14 April 2001). The British comment about Germany reads:

‘Germany: Euthanasia is a highly sensitive issue. The administration of a deadly drug is regarded as murder’ (Guardian, 11 April 2001).

The German comment about Britain reads:

‘Grossbritannien: In Grossbritannien ist die Sterbehilfe gegen das Gesetz. 1993 and 1994 ermaechtigte die Justiz jedoch Mediziner, das Leiden von Patienten zu beendigen, die kuenstlich am Leben gehalten werden. In Schottland erhielt eine Patientin im Juni 1996 zum ersten Mal die “Erlaubnis zum Sterben” [Great Britain: In Great Britain, euthanasia is against the law. In 1993 and 1994 however, the courts authorised doctors to end the lives of patients who were artificially being kept alive. In Scotland in 1996, a woman was firstly “allowed to die”] (Wendlinger Zeitung, 14 April 2001).

These short captions cannot do justice to the complexity of the issues as they appear in the respective countries. What they can do is to create the impression that euthanasia is an international, and not just a Western but - with the introduction of a reference to China in the Guardian - a world-wide issue (a global issue?).

That is as far as the similarities go. The differences have really to be seen in the detail of the discussion determined by the historical and social context of the different countries. In Germany, the history of Nazi euthanasia programmes during the Nazi dictatorship is a constant negative reference point in discussions of euthanasia. The

word 'Euthanasie' derives its negative connotations from that time, and today the term 'Sterbehilfe' ('help with dying') is preferred⁴. Maybe as a consequence, the situation in Holland is presented in a more differentiated way and not as negatively in the German as compared to the British press, where Holland represents the negative reference point, while reference to the history of Nazi Germany does not appear. This extract should give an example:

'Sie nennen es Euthanasie, und uns ueberlaeuft es kalt. Wir denken an "unwertes Leben", die Nazis – und blocken ab. Dies aber ist ein deutsches Problem, ausschliesslich ein deutsches. Erstens sind die Niederlande keine Moerderbande. Zweitens bedeutet Euthanasie, griechisch fuer guter oder auch schoener Tod, laut Lexikon schon die Erleichterung des Sterbens, besonders durch Schmerzlinderung mit Narkotika' [They {the Dutch} call it euthanasia, and we get the cold shivers. We think of "life unworthy of life", the Nazis – and block it out. This however is a German problem, and only a German one. Firstly, the Netherlands are no gang of murderers. Secondly, euthanasia, Greek for good or beautiful death, means according to the dictionary the easing of dying, especially through the reduction of pain with narcotics] (Frankfurter Rundschau, 12/13 April 2001).

Paradoxically, the awareness of the particularity of the German historical context seems to lead to an attention to the particularity of the other country, Holland – but by reference to the 'real', original meaning of the word 'euthanasia', ultimately with the aim of making a universal point that in turn has repercussions for the particular German context with regards to euthanasia. The same Greek definition is also used in British newspaper discourse to make a particular rhetorical point: both here and there, the particular definition of euthanasia already places the speaker/writer into a particular version of the discourse on euthanasia. It is clear that if a positive definition

⁴ See Battin (1994) on euthanasia in Germany – as well as PAS: while the term 'Euthanasie' has more negative connotations in German than its English equivalent, German has several categories for suicide one of which, the term 'Freitod' ('free death' or 'voluntary death') has positive connotations that are absent from the English term 'suicide'. Battin argues that the German language thus opens up a conceptual space for an acceptable type of suicide (and by extension, and that is the core of her argument, physician-assisted suicide) that the English language is lacking, obstructing the way to a positive understanding of any type of suicide.

of euthanasia is chosen, a positive attitude to euthanasia is implied: calling euthanasia the ‘good death’ is making a rhetorical point in support of euthanasia.

In conclusion to this section it can be said that at least in the case of Britain and Germany, discussion of euthanasia in newspapers consists of largely a similar structure of argumentation, even though the discussion is geared to the particularity of the national social and political (and historical) context. Reference to other countries is made in both cases, where the objective and/or effect is not to deepen an understanding of what happens in other countries, but to support a rhetorical point. What is said to happen or not to happen *there* gets universalised, and the universal leads back to the particular and directs what will or should happen *here*. The quote above is an even more complex example of the same basic structure: what happens here is different to what happens there, but that is because we are different; but maybe we are particular whereas (and from here it is the same as above) what happens *there* is universal and thus is the standard for what will or should happen *here*⁵.

In conclusion to this whole part it can be said that in newspapers, euthanasia is discussed within particular national contexts. Rhetorical arguments strategically make references to particular countries to make universal claims that translate into particular claims for one particular country. A major side-effect of this is that the concept of national societies is promoted and strengthened by this kind of discourse, and is by no means in the process of disappearing.

Real places versus rhetorical strategies:

(a) the rhetorical use of the term ‘world’

We have seen that the units in which newspaper articles frame their discussions of euthanasia are countries. These countries are either put into a category of their own, constituting their own world, or put into the category of the universal, where processes happening in one country are imagined to apply anywhere in this world regardless of particular contexts. The word ‘world’ I have used here deserves some attention, for does it not refer to the same thing as the global? ‘World’ can mean the

⁵ To spell this out for the sake of clarity – the argument goes that what happens in Germany is different to what happens in the Netherlands, because of our different histories; but maybe we (Germany) are the odd ones out, which would mean that we should take what happens in the Netherlands to represent the universal standard for what should happen also in Germany (what happens in the Netherlands being

globe, but it does not have to. In the newspaper discussions on euthanasia, ‘world’ refers to a self-contained whole. There can be several worlds, and these worlds have no point of connection with each other. Here are some examples (coming from the Dr. Moor case, the Kevorkian case and the case of the woman trying to kill her husband):

‘The Dutch parliament is considering legislation to allow euthanasia – which would make it the only country in the world to allow the practice’ (The Journal, 12 May 1999).

‘EUTHANASIA: CONTROVERSY AROUND THE WORLD’ (headline, Guardian, 12 May 1999).

‘The subject of euthanasia is one which inflames opinion the world over [...]’ (Bath Chronicle, 14 June 1999).

The world referred to here is the globe, or all the countries on the globe. ‘The only country in the world’ states a fact about one country among all other countries. ‘Controversy’ and ‘inflamed opinion’ around the world conjures up images of the globe and wherever one looks, people are putting their heads together discussing euthanasia. This is a rhetorical use of the concept of the world, not literal, conveying the urgency of the topic rather than saying something that is really happening everywhere. It is relating to something real, as under the headline of the Guardian a list of countries and their legal context concerning euthanasia is discussed (see above), suggesting that people in other counties do discuss the issue. However, whether that literally justifies talking about the whole world is doubtful.

The next set of quotes is not about the globe:

‘VERDICT FUELS ROW IN THE MEDICAL WORLD’ (headline, Herald, 12 May 1999).

‘Choice is what puts humans above the animal world’ (Northern Echo, 12 May 1999).

universally valid). Our particularly odd, historically conditioned, approach to euthanasia should yield to the universal reason of the Dutch example.

‘We can regret the passing of the world of complicity. The world in which we now live will not allow it’ (Independent, 12 May 1999).

‘’There is a world of difference between going out and violently killing a stranger and helping a loved one to die’’ (Herald Express, 13 February 1999).

Instead of referring to one world, the one encompassed by the globe, these quotes talk about different worlds. Worlds are imagined as self-contained wholes that have no connection with each other. Reference to the medical world or to the animal world constructs the entities belonging in those worlds (medical professionals, animals) and their interactions with each other as Other, as far removed, as utterly different (from, as implied, the non-medical or the human world). The ‘world of complicity’ of the past is severed from the ‘world in which we live now’, and ‘worlds of difference’ are constructed between two actions that could also be put under the same heading: ‘violently killing a stranger’ and ‘helping a loved one to die’.

The word ‘world’ is thus a flexible concept that we can think with. It is not only tied to real physical space, but can conjure up imaginary spaces. The ‘world’ is a concept for thinking a whole, but it doesn’t specify what whole. The world of the globe, of the earth can be opposed to the world of space. The world of humans can be opposed to the world of animals. Invoking worlds is invoking difference, incompatibility and incommensurability. The concept ‘world’ works on different levels, it can refer to the globe but it does not have to: it can also work in terms of a spatial reference (either larger or smaller than the globe), or it can discard that spatial reference altogether.

(b) Nationalism as an ideology

In his book ‘Banal Nationalism’ (1995), Michael Billig presents an analysis of the structures of nationalism. He reminds us that ‘nationalism as an ideology [...] was always an international ideology’ (p.53). In that sense, it has never been inward looking – nations have always looked towards other nations. Billig says:

‘Nationalism inevitably involves a mixture of the particular and the universal: if ‘our’ nation is to be imagined in all its particularity, it must be imagined as a nation among other nations’ (p.83).

‘The particular nation can claim to talk for the whole world: ‘our’ particular interests can appear as the interests of universal reason’ (p.88).

In British newspaper reporting on euthanasia, we can see exactly that being played out: the comparison of Britain with other countries – for it matters for a nation in the international system what happens in other nations – as well as the search for a universal rationality for what should happen here. The same seems to go for the current struggle over human rights: it is a struggle over the universality of human rights on the international level by countries who have their particular version of the human rights they hold to be universally applicable. It is hard to see what a concept of the ‘global’ can add to this analysis⁶.

Discussion of euthanasia in British newspapers is being conducted in and for the present British context. This discussion includes statements about morality that are general and not restricted to this country (having universal rather than global application), for example:

‘[...] if a patient whose life has been all but destroyed by a debilitating and painful disease explicitly requests to be freed from their suffering, the only humane course of action is to comply’ (Birmingham Post, 13 May 1999).

Much more, though, the particular British conditions (practices, laws) are referred to:

⁶ It is tempting to add at this point to add with Billig that ‘the theories of national identity and postmodernity, which assert the decline of the nation-state, are being formulated at a time when a powerful nation, the United States of America, is bidding for global hegemony. The global culture itself has a national dimension, as the symbols of the United States appear as universal symbols’ (p.11). Billig’s analysis of nationalism in an international world can deal with this issue. Imagining the world to be ‘globalised’, on the other hand, will have the tendency to divert attention away from issues of power differentials between nations.

‘The law on euthanasia in Britain is perfectly clear -- if you shorten someone's life even for a few moments then you are committing murder’ (Northern Echo, 12 May 1999).

‘A survey in 1994 revealed that one in three doctors in Britain had performed euthanasia. A further study by BBC TV's Close Up North in 1997 revealed that of 250 North-East GPs, 84 admitted carrying out euthanasia’ (Northern Echo, 12 May 1999).

The British context is not only constructed by reference to its particular laws and practices, but also by constructing a British history:

‘Dr Moor, who practised in Newcastle upon Tyne, was the first British doctor to be tried for murder purely for the mercy killing of a patient. In the only other murder case that of John Bodkin Adams in 1957 the crown alleged that the doctor profited from the death of an elderly widow. He was acquitted’ (Guardian, 12 May 1999).

In British newspapers, euthanasia is presented as a problem of and for Britain, which is constructed in terms of the prevailing social conditions in this country as well as universal morality. Reference to other countries is instrumental in this construction. Euthanasia in other countries is discussed in articles that have euthanasia in another country as their topic. The global does not appear.

Conclusion

Previous chapters have shown that euthanasia is presented in British newspapers as a problem. This chapter has shown that that problem is constructed as a problem of and for Britain, or of and for another country. There are two reasons for this, one external and one internal to the press: firstly, individual countries still set the law through which the legal status of euthanasia within a particular country is defined. Secondly, newspapers are still being produced for the local or the national market, and this defines their reference points as to who and what they write for.

In this chapter, I found that in contrast to the current importance of the global in the thinking in the social sciences, the global is a category that is irrelevant to press discussions of euthanasia. I came to see that the nation/the national is still immensely relevant here, which leads me to tentatively make the general point that a one-sided emphasis on globalisation (even if it incorporates its opposite of regionalisation) may obscure the importance that states and nations still possess in the contemporary world – both in people’s cognitive understanding of the world and in the organisation of our lives. Maybe the disappearance of the nation state is a phenomenon more internal to social scientific thinking than of the external world.

My discussion of globalisation and the global has of necessity been relatively simplistic in this chapter. The global is not only imagined as a whole with its own properties. There are attempts to imagine the global in more sophisticated ways. Urry in his recent book ‘Sociology beyond societies’ (2000) takes as his starting point that the social as society has to be rethought in terms of the social as mobilities. Attention has to be shifted from what happens within particular nation states to investigating the networks and flows that crisscross the borders of nation states. There is no doubt that there are processes in the social world that cannot adequately be explained within the framework of the particular conditions of a particular society. The fact that opinion polls in several countries (at least in the Western world) consistently show a massive increase of public support for euthanasia over the last decades, now reaching 60% to 90% in favour of euthanasia (that is, a majority regardless of who does the survey and how the questions are phrased), suggests that there are reasons for this which transcend the particularity of national contexts.

Attention to networks and flows has the advantage that it can both tease out what networks and flows exist, as well as what networks and flows are blocked. Attention to mobilities must involve attention to struggles over mobilities. This is an extract from a recent newspaper article:

‘DOCTOR PLANS EUTHANASIA BOAT IN UK WATERS

An Australian doctor plans to moor a floating euthanasia clinic off the UK administering lethal injections and drug dosages in an attempt to raise the political profile of the mercy killing debate [...].

Dr Nitschke is investigating whether the Dutch parliament's recent decision to legalise euthanasia would enable him to circumvent the law in Australia, Britain and other countries where the practice is illegal [...].

A spokesman for the Dutch health ministry said the project would be impossible under their legislation, as the patients must have a long-standing relationship with the doctor and get a second opinion from another physician [...] (Guardian, 19 June 2001).

Here, Dr Nitschke, who wants to break through the boundaries set by nation states, comes up against the laws of those states. His mobility is restricted by the laws of nation states.

Within globalisation theory, there are two contrasting ideas: one that says that globalisation (networks and flows) is just happening and will eventually make the nation state redundant. The other holds that globalisation is dependent on nation states, that it 'presupposes the tacit *consent* of national states' (Beck 2000, p.37). Beck outlines Gilpin's approach (which he does not agree with) that suggests that 'globalisation is necessarily *contingent* and under threat, in the sense that the emergence and development of transnational social spaces and players presupposes a hegemonic power structure and an international political regime' (ibid). The fact that the jury is out on whether the global or the nation are the primary driving forces behind social and other developments in the contemporary world leads me to think that the answer might be different for different processes. With regard to euthanasia, the structure of thinking might be similar in different countries due to processes that transcend the nation state, yet at the same time the nation state still has the power to set and enforce the laws relating to euthanasia. While both the British and the German newspapers use references to other countries as a rhetorical strategy in their argumentation, the same country (Holland) is represented in radically different ways: either as the positive example that should be followed, or as the negative reference point of how *not* to do it. Whether the different countries that are debating euthanasia at the present time will develop similar or very different approaches to the regulation of euthanasia remains to be seen.

Chapter (9) - Conclusion

Introduction

The study of media representations of euthanasia deals with a topical issue: euthanasia has arrived on the agenda in Europe, where the European Union strives for ever greater integration between its member states, since two of those members - the Netherlands and Belgium - have made some form of euthanasia legal. This is only one of the reasons that euthanasia is being debated in Britain. Britain has its own long-standing debate about euthanasia, which so far has never resulted in practical social policy neither in terms of involuntary euthanasia (or mercy-killing), nor any form of voluntary euthanasia. Britain's particular contribution to the improvement of the situation of the terminally ill and dying (particularly of cancer) has been the development of the hospice movement and the medical speciality of palliative care, which has spread to other countries. This has become the context in which euthanasia is being debated in Britain, where many argue that hospice is the answer to all the problems of the dying, and that consequently there is no need for euthanasia at all.

Yet, support for euthanasia has been rising – the Voluntary Euthanasia Society has developed from an elitist group into the voice of what is perceived to be a popular movement. This rise of the support for euthanasia is explained by the increasingly widely-held and deeply felt belief that individuals should be able to make decisions regarding their own lives, including their deaths.

It is the current debate about euthanasia that has been the focus of interest in this thesis, which has been approaching the euthanasia debate through its expression in newspapers.

Press discourse and expert discourse

It has been noted already in the introduction, and was repeatedly stated throughout the chapters of this thesis, that the purpose of this study was not a concentration on the

differences between newspapers, but an exploration of newspaper coverage as a whole. If there was an implicit comparison, it was the comparison between expert discourses on euthanasia and the media presentation of the issues. Expert discourse is characterised by the struggle over categories and boundaries, and at first sight it appears that the press coverage echoes the way that experts argue the pros and cons of euthanasia. At first glance, too, the media seem to report on the issues in a balanced way – presenting ‘both sides’.

However, far from just presenting a balanced picture, or having regard to the categories and boundaries present in expert discourse, I found media discourse to expound a tentative support for a particular kind of euthanasia: voluntary euthanasia of a terminally ill person – whereby the concepts of ‘voluntary’ and ‘terminal illness’ were used in a flexible way and little importance was given to any boundary between ‘killing’ and ‘letting die’. Euthanasia as a ‘good death’ is a definite feature of press discourse. This does not mean that every single article on euthanasia that appears in the papers argues this, but it does come out of a body of articles collected from different British newspapers over the course of one year.

In one more respect, newspaper coverage of euthanasia seems to follow expert discourses on euthanasia: discussion in medical ethics revolves around individual cases that are presented as dilemmas. Newspapers discuss euthanasia within reports of a particular case that has come before court or have been brought to the attention of the police. The implicit assumption, both in the discussion of cases in medical ethics and cases in newspapers, is that there are general categories that can be applied to a case resulting in the solution of a dilemma, a solution which in turn will be applicable to other similar cases. However, a closer look at the elements of the cases as they are represented in the newspapers tell another story: far from the picture of a dilemma faced by an individual, and potentially solved by an individual, we see conflicts between different groups: between doctors and patients, patients and relatives, relatives and doctors, doctors and nurses, any of those and the state – and it does not follow which group will support what course of action. In addition, most of these conflicts take place in institutional settings – hospitals or nursing homes. This fits in with what other critics of the approach

of medical ethics have said, for example the sociologist Daniel Chambliss who has looked at the work of nurses in American hospitals:

‘The language of dilemmas individualises ethics, making morality a personal issue. The individual is advised to get more education, to change her thinking, to clarify her principles. ‘Dilemma’ refers to an ethical difficulty as something to be solved in the mind of the professional person, an internal balance of positions. The troubled person is said to ‘be conflicted’, as if in a fight with herself. This neatly avoids the possibility that she has a conflict with someone else’ (Chambliss 1996, p.92).

Chambliss also says that ‘ethical issues reflect conflicts of groups’ moral agendas’ (p.96) – however, these moral agendas, in relation to euthanasia, are far from straightforward. Relatives may variously want to see the suffering of their loved ones to be ended by whatever means, or reject any intervention by medical professionals that could have the result of shortening what they conceive of as the ‘natural’ life-span. Doctors may variously want to attend to their duty to save life, or follow a moral obligation to relieve suffering. Nurses may see their duty in caring for a dying person till the end, or find that caring might mean ending the agony. From the cases that made it into the newspapers in the year that I studied, we can follow that it is near impossible to predict what precise form a conflict will take.

The composite picture that arises from looking at a range of cases in newspapers that are discussed in terms of euthanasia then gives us interesting results that a narrow concentration on individual cases - as individual cases - cannot produce.

What about the taboo on killing?

The most striking difference between expert discourse (particularly philosophical discourse), and press discourse, on euthanasia is the different emphasis on the boundary between ‘killing’ and ‘letting die’. For expert discourse, this boundary is crucial – in press discourse, the boundary seems to all but dissolve. This seems to me to point to an

essential difference in the conceptualisation of the life of individuals in society: expert discourse seems to hold that the categories and boundaries are what matter principally – categories and boundaries found to be correct have to be upheld even if this causes deep rifts within society (those categories and boundaries, if they are not supported by all, having to be enforced by power). Abstract moral imperatives are valued over a life in a society of harmony. With respect to press discourse, a charitable interpretation would find that priorities seem to be reversed: it appears that the achievement of living in harmony is valued over the importance of the defence of abstract principles.

In philosophy, it is often argued that the taboo on killing represents an essential boundary that guides our actions, and if that boundary is being eroded, for example by allowing some form of euthanasia – as has happened in the Netherlands and Belgium very recently –, then the taboo on killing in general will be weakened and it will automatically follow that all kinds of killing will become habitual in our society. This is what is called the ‘slippery slope’ argument. It is immediately obvious that seen from this standpoint, the blurring of the boundary between ‘killing’ and ‘letting die’ in press discourse must appear menacing and threatening. From the point of view of philosophy, cognitive categories are primary: the only reason why we do not go round killing people is because we have this category in our head that says: don’t kill. However, we can also think of categories as abstractions from our experience in society: this experience is shaped by learning as children from the example of those around us, and as adults through our engagement with those we interact with (following Barry Barnes (2000) who has defined human beings essentially as mutually susceptible and mutually accountable creatures). Rather than rigid cognitive categories, we learn strategies of how to respond to complex situations. In the light of these considerations, it seems unlikely that the legalisation of a defined form of euthanasia will result in anything like a switch in our cognitive categories from ‘don’t kill’ to ‘do kill’, leading to an actual increase in killing. In fact, this assumption starts to look rather too simplistic.

The fundamental collective sentiment in media representations of euthanasia

It seems, then, that the fundamental collective sentiment present in media representations of euthanasia is not that no human being should ever kill another human being under any circumstance. Rather, the fundamental collective sentiment appears to be the appreciation of the tragedy of terminal illness which is seen to warrant radical measures, including euthanasia. We have seen that the ‘voluntary euthanasia discourse’, which is based on the autonomy of the individual, forms part of the press discourse on euthanasia, but that it is secondary to what I have called the ‘terminal illness discourse’. The ‘voluntary euthanasia discourse’ starts from the premise of the autonomy of the individual, assuming that the autonomy of the individual means that individuals should be allowed to make their own decisions at the end of their lives, including make the decision to die from euthanasia. The weakness of this argument is that euthanasia is fundamentally a social issue, by definition always involving more than one person: one person who kills and another person who dies. There are attempts at making this social connection less obvious, for example by advocating physician-assisted suicide (where the person who kills and the person who dies are one and the same). However, ultimately it cannot be denied that there is always a social dimension to the problem – even in physician-assisted suicide, the physician is involved in the action, and society is involved by sanctioning the action. As Durkheim said: ‘liberty [...] is always the product of a set of rules’ (Durkheim 1991, p.xxxiii). While for many supporters of euthanasia, the ‘cult of the individual’ (Durkheim) provides an answer to the problem (‘individuals should decide for themselves, that’s why we have to allow euthanasia’), for Durkheim, the ‘cult of the individual’ constitutes only the beginning of finding an answer to the problem. For him, increasing individualisation means increasing liberation from both from the organic and the social environment (p.335). Increasing individualisation, then, both gives us the freedom to make up our own rules – and at the same time gives us the responsibility of making up rules that are just, for we cannot defer to ‘some ideal powers completely different in nature from ourselves, powers who follow their own course without heeding the interests of men’ (p.338). In a sense, we are condemned to be free. We cannot defer to nature or Gods, we are the only agents of our individual and social lives. The

autonomy of the individual then does not provide us with an argument in support of euthanasia, all it does is provide us with the reason for our obligation to make up rules about euthanasia that are not based on arguments that displace the agency to make up those rules from human beings unto ‘powers completely different in nature from ourselves’.

‘Terminal illness discourse’

However, the ‘terminal illness discourse’ in press discourse on euthanasia does just that. It holds that the presence of terminal illness can justify euthanasia. In a sense, the rhetoric of the ‘terminal illness discourse’ displaces the responsibility to make up the rules on euthanasia from people onto nature. It argues that nature made the rules in the first place; in the case of terminal illness, nature wins out over people by killing a person, without other people being able to prevent this. Euthanasia, in this understanding, only takes partial responsibility for the death of the ill person – nature, which is given agency in this conceptualisation, shares in the responsibility for the death¹. In Durkheim’s time, the

¹ The question of the attribution of agency and responsibility - to humans or ‘nature’ respectively - is also coming up in a more recent argument employed in relation to euthanasia. Since the full implementation of the European Convention on Human Rights into British law through the Human Rights Act 1998/2000, Article 3 is being invoked to argue in favour of euthanasia. This article states: ‘No one shall be subjected to torture or inhumane or degrading treatment or punishment’. The recent Diane Pretty case – a motor neurone disease sufferer who lost her case in the British High Court to allow her husband to help her to commit suicide – made reference to this article, which was also reported by the newspapers (for example: Guardian, 29.11.01). The law regulates the conduct of people in relation to each other. Therefore, a claim in favour of euthanasia based on Article 3 would have to argue that continuing medical treatment amounts to torture. In that sense, it would follow that medical treatment would have to stop, but not that a suffering person should be killed. A cursory search for the application of the word ‘torture’ in arguments on euthanasia on the Internet reveals different ways of understanding what amounts to torture:

- People are understood to be ‘tortured by their underlying disease’;
- Somebody is said to have endured ‘almost four years of endless torture from cancer’;
- It is considered to be inconceivable that ‘doctors are standing by ineffectually while torture continues’;
- ‘life is indistinguishable from torture’;
- ‘it is complete torture to allow the patient to suffer past his or her wishes’
- ‘inadequate palliative care’ is understood as ‘torture’;
- and also, ‘medical technology will be made to torture them’.

What has to be concluded from this admittedly random exercise is that a person can be understood to be tortured either by medical professionals administering medical treatment, but equally by a disease (nature) and by medical professionals not responding adequately to reduce the effects of torture by the disease,

relationship between human beings and nature (both in the sense of our biological make-up and the external environment) was conceptualised in terms of an evolutionary progression in humanity's increasing emancipation from nature. Today, our extraordinary scientific and technological achievements are simultaneously pointing towards the limits of humanity's emancipation from nature. The re-conceptualisation of the relationship between humanity and nature is a major issue for contemporary society. The shift can be characterised by the move away from an opposition of humanity and nature, to a more integrated view of 'humanity in nature'. From this position, the view that human beings and nature are to a certain extent sharing agency and responsibility in a holistic world where everything is interconnected does make perfect sense. However, even when we conceptualise terminal illness as sharing in the responsibility of death by euthanasia, the involvement of the human agents means that we are not able to abstain from all responsibility. The idea that nature is sharing in our responsibility does not translate into a particular prescription for the actions of the people involved. What this rhetoric does is make the people involved in euthanasia in the context of terminal illness less responsible, make the killing less morally prohibitive than killing in other circumstances.

Press discourse on euthanasia combines the 'voluntary euthanasia discourse' and the 'terminal illness discourse'. Both discourses work together to provide a justification for euthanasia in the case of a terminally ill individual who asks for euthanasia, justified first of all by the creation of a category of killing which is less morally prohibitive than killing in general (terminal illness), and secondly by invoking the right of the individual inflicted as such (by terminal illness) to make their own decision about wanting to be killed in

therefore becoming complicit with the disease (nature). Agency and responsibility for torture is thus attributed either wholly to people, wholly to nature, or understood to be shared between people and nature. I want to argue that it is only possible to apply Article 3 in an argument favouring euthanasia, if one understands torture to be resulting primarily from the disease (nature), leaving medical professionals only the option to either be complicit with disease (nature), or 'do something' to stop the torture, up to the point of killing the victim of torture. It can be seen from the quotes above that doctors in general are not seen to be neutral. Therefore, we have the curious situation that a law that aims at regulating conduct between people may be invoked on the basis of an attribution of agency and responsibility to 'nature'. The above can be seen as a version of the 'terminal illness discourse' (where agency and responsibility is understood to be shared between people and 'nature') which is present in newspaper articles on euthanasia, thus further testifying to its wide application and legitimacy.

those circumstances. In that sense, together they open up a space where decisions about euthanasia can be made. While in the press, both discourses are often used separately to make arguments in favour or against euthanasia (as if the presence of ‘terminal illness’ would not just justify but proscribe euthanasia; as if rules in society should be changed purely on the basis of wants of individuals), together, as I hope to have shown in this theoretical elaboration of my findings, they point towards the fundamental collective sentiments that form the basis for understanding the large public support for euthanasia. Although voices arguing for the prohibition of euthanasia under every circumstance with reference to the fundamental taboo on killing can be found in the press, their marginalisation must mean that euthanasia is seen to be a subject that is open to discussion, in that agency and responsibility for euthanasia (even if conceptualised as shared) rest firmly with us human beings. The press thus seems to express implicitly what Durkheim theorised explicitly: that it is us who have to make rules for ourselves, and that making arguments that invoke the reference to ‘powers who follow their own course without heeding the interests of men’ is seen as illegitimate.

Morality and the law

As Durkheim says,

‘law and morality represent the totality of bonds that bind us to one another and to society, which shape the mass of individuals into a cohesive aggregate. We may say that what is moral is everything that is a source of solidarity, everything that forces man to take account of other people, to regulate his actions by something other than the promptings of his own egoism, and the more numerous and strong these ties are, the more solid is the morality’ (Durkheim 1991, p.331).

In the case of euthanasia, law and morality seem to be moving apart. There are those that argue that the law must express ideas of morality (thus euthanasia should be legalised), and there are others who say that the law must create a sense of morality (thus euthanasia should remain illegal). Either way, law and morality are recognised to be intimately

connected. While legislation is limited to a particular jurisdiction, morality today is understood to be something transcending borders. Morality has come to be associated with humanity as a whole – something that does not necessarily need to be the case, considering that throughout the history of humanity, there have been groups whose ideas of morality have differed significantly depending on whether they concern their own people or strangers. For Durkheim, morality is part of the collective conscience of the group, for ‘where should we turn to look for the characteristics of our model if it is not within ourselves and those around us?’ (Durkheim 1991, p.329). Durkheim’s ‘group’ is the nation. Since he wrote, increasing individualisation, mobility and information technology have transformed our ideas of the nation – the ties binding the individual to the nation have been weakened (not disappeared), while groups smaller than the nation and transcending the nation state appear to develop a collective conscience. Barry Barnes’ (2000) definition of human beings as ‘mutually susceptible and mutually accountable’ creatures who create culture as a matter of course seems to fit the contemporary condition of mobilities better than the concept of ‘collective conscience’ which raises the question as to what that collectivity is that it is referring to: is it the ‘nation’, is it ‘society’? Is it a ‘subculture’? Essentially, however, Durkheim’s and Barnes’ concepts are not so different, only with respect to the definition of the ‘collective’ in ‘collective conscience’. We have seen that while newspapers still operate primarily in and for a national context, thus continuing to promote the concept of the nation, moral questions are discussed in terms of universal moral rights and wrongs – in terms of how human beings should treat each other. With regard to euthanasia, a quest for a universally valid morality that should be reflected in national law is indicated by the frequency with which cases and developments involving euthanasia not just in Britain, but in other countries are reported in the British press. Reference to the situation in other countries is a recurring feature of newspaper articles on euthanasia. In most cases, the reference to another country is used as a rhetorical device to support a particular argument – it serves its purpose within the structure of the article, it never does justice to the complexity of the country’s situation. However, in my view this does not mean we should dismiss the importance of the recurring reference to other countries which is such a substantial feature of press discourse on euthanasia as doing nothing but serve an

argument – it also legitimises that kind of argument. The House of Lords Select Committee on Medical Ethics in 1994 decided not to recommend a change in the legalisation regarding euthanasia in Britain partly on the basis of what they had seen on a visit to the Netherlands. How far the situations in two countries as different as the UK and the Netherlands in all matters of history, culture, social arrangements and so on can be compared in a straightforward way is a question that is asked less and less if any simple reference to another country is easily accepted as a valid argument (promoted by press discourse on euthanasia).

The particularity of expert discourses

The media have often been shown to present a simplistic picture of complex issues. From the point of view of expert discourse, this might actually appear to be the case. However, if instead of comparing how experts and how the media represent complex scientific (or, in this case, moral) issues – starting from the categories given in expert discourse – one is prepared to look at media discourse in its own right, then, in addition to gaining a better understanding of what media discourse is all about, one might obtain a new appreciation for the particularity of expert discourses.

The problem posed by the increased public support for euthanasia in the light of a continuing prohibition of killing in law and codified medical ethics will not be resolved by expert discourse – the struggles of philosophers, lawyers, theologians and clinicians over categories and boundaries. What is needed is a much better understanding about what abstract categories like killing or letting die might mean to people in the context of their lives. A lot more work (see below) has to be done before we can clarify whether the newspapers' blurring of the boundaries between killing and letting die is a disturbing sign, foreshadowing an increasing brutalisation of society, or indeed a sign for the maturity of the public in its response to complex moral issues. If it is found that the taboo on killing is indeed not the most fundamental collective moral sentiment that structures people's ideas about euthanasia, then all of society will have to come to terms with that.

The fact that 'terminal illness' is of such relevance to press discourse on euthanasia, that 'terminal illness' is evocative particularly of cancer, and that it is the hospices that

deal mainly with terminally ill cancer patients, means that in practice, the findings from this study of euthanasia in the media will be of particular importance to the hospice movement – especially considering that the hospice movement is vehemently opposed to euthanasia (even though individual hospice workers may feel differently). The issue of euthanasia will have to be addressed by the hospice movement; this is what some commentators on contemporary palliative care (palliative care having moved beyond hospices) are already arguing. Their ‘viewpoint emphasises the need for palliative care to itself become reflexive in orientation, more willing to take on the position of the other (particularly ethical matters relating to euthanasia) [...]’ (Clark and Seymour 1999, p.179).

The message that the media gives out about the link between ‘terminal illness’ and euthanasia will be of particular concern to people with cancer, people who treat them and those who fund research into cancer. It is only through the concerted effort of all the different groups who come into contact with cancer and cancer patients that the image of cancer has changed over the last few decades from an illness that stigmatises its victims to one that has lost those connotations². An automatic link between cancer and euthanasia in the public mind cannot be regarded as desirable by those groups, in a context where euthanasia is regarded as controversial. There may be a moral change taking place where the absolute prohibition on killing is coming to be seen in more relational terms by large parts of society (thus justifying talking about a ‘fundamental collective sentiment’). At the same time, it is generally acknowledged today that neither ‘society’, nor any other collectivity, can be considered to form a coherent unit. A ‘fundamental’, or widely shared, ‘collective sentiment’ will still be countered by other sentiments and arguments, for as Billig says, an argument is always ‘arguing against’ something. For both the social reproduction of morality and moral change to take place, the argument has to continue.

² Susan Sontag observed already in 1988 that in the decade since she wrote her book on tuberculosis and cancer (‘Illness as a metaphor’), ‘attitude about cancer has evolved’, and ‘cancer is not as much as a stigma’ anymore (Sontag 1989, p.15).

Final comments

When I started work on this thesis, there was no country in the world in which euthanasia was legal (apart from a short period of time in Australia's Northern Territory and several attempts in Oregon, USA – in both places the pressure to legalise euthanasia was met by equal pressure to keep it or make it again illegal). In Europe, the Netherlands have had a long history of consensus building over euthanasia. Euthanasia was first decriminalised, meaning that doctors could practice it, escaping prosecution if they kept to strict guidelines. In April 2001, euthanasia was finally legalised. Since then, Belgium has followed suit – in October 2001, new legislation on euthanasia was passed by the Belgian Upper House (still awaiting approval from the Chamber of Deputies, regarded as a formality) (Guardian, 26 October 2001).

One curious characteristic of working with newspapers is that they are read for information, and they are read for analysis. Nowhere else did I learn about the legalisation of euthanasia in the Netherlands and Belgium. Both events happened after the time period (1998/99) covered by the data in my thesis. After analysing this data, I now read more recent newspaper articles with a view to how they are similar and how they are different to my data. Looking at the Guardian article on the legalisation of euthanasia in Belgium (see above), I can conclude that the same features are still there: a survey is mentioned (three quarters of the Belgium population in favour of euthanasia), quotes from people arguing for as well as against euthanasia are given, the conditions under which euthanasia has become legal are presented. I mention this here because I want to point to one thing that seems to have changed since I gathered my data. The first paragraph of the article reads:

‘Belgium became the second country in the world to approve a law legalising euthanasia last night. The move will give fresh impetus to campaigns for legal mercy killing elsewhere in Europe – especially in Britain, France and Italy, where significant movements are pressing for it’ (Guardian, 26 October 2001).

In my data, nowhere did I read about 'movements'. This is significant not only in itself, but also because in the last couple of years social scientists have directed their attention to the social movement character of the organised pressure for legalising euthanasia³. This is an aspect that I have not looked at in this thesis as it did not appear in my data. However, apart from this it seems to me that although my data is a few years old, the issues it raises and that have been analysed are more pertinent now than ever.

This study into media representations of euthanasia has been very data-led. The data was selected on the grounds that it was recent. Therefore this study makes generalisations that may be particular to the time period selected. Further projects could look into whether there are differences to be detected over time, by effecting a comparison with a time period either nearer to the present or further into the past. The comparison with Germany could have been expanded and put on firmer methodological basis by obtaining a data sample large enough to be equivalent to the British sample. My findings in that area thus have to remain provisional.

Further research could concentrate on a more systematic international comparison of press coverage of euthanasia in different countries. Such a systematic comparison could well be conceived in terms of a content analysis, making use of the findings of this study: it could, for example, investigate one particular issue, such as the portrayal of the relation between euthanasia and terminal illness.

The findings of this study could be tested by conducting interviews with a range of people, to see how far their views endorse or differ from the predominant contemporary media representations of euthanasia. Another interesting research project could be to take a closer look at the actual construction of questionnaires that aim at establishing people's views on euthanasia, to find out about how they represent people and how they normalise particular ways of talking about euthanasia.

A further exploration of the patient-doctor relationship as it is played out in relation to the subject of euthanasia could make an interesting case study providing us with more information about the dynamics of medical authority in a consumer-oriented society.

³ For example: 'Requested Death': a new social movement' by F. McInerney (2000), 'Come Lovely and Soothing Death: The Right to Die Movement in the United States' by Elaine Fox et al (1999).

More work also needs to be done situating the euthanasia debate within social theory, theorising it in the context of postmodern society, risk society, globalisation, and so on.

Appendix

Below is the list of LexisNexis British newspaper sources – the underlined newspapers are the ones that were mentioned in the ABC list of British newspapers and The Newspaper Society’s lists of Top Ranking Regional Newspapers by Circulation. The starred newspapers are those newspapers that did not appear in the above mentioned lists, but yielded data used in this thesis (see next page):

- AAP News (Global News Wire from Financial Times)
Aberdeen Evening Express
Aberdeen Evening Express (Northcliffe Newspapers)
Aberdeen Press & Journal
Aberdeen Press & Journal (Northcliffe Newspapers)
× Bath Chronicle ×
× Belfast News Letter ×
Belfast Telegraph
Belfast Telegraph (Global News Wire from Financial Times)
Birmingham Evening Mail
Birmingham Evening Mail (England) (Marketing and Advertising Reference Service from Information Access Company)
Birmingham Post
The Birmingham Post (England) (Marketing and Advertising Reference Service from Information Access Company)
Birmingham Post (Europe Intelligence Wire from FT Information LTD.)
The Birmingham Post (Global News Wire from Financial Times)
Bristol Evening Post
Bristol Evening Post (Global News Wire from Financial Times)
The Business
Business a.m.
Business Telegraph (Global News Wire from Financial Times)
Chemical Business NewsBase
Chemical Business NewsBase: The Independent (Global News Wire from Financial Times)
Coventry Evening Telegraph
Coventry Evening Telegraph (England) (Marketing and Advertising Reference Service from Information Access Company)
The Daily Mail and Mail on Sunday (London)
Daily Mail (Europe Intelligence Wire from FT Information LTD.)
Daily Mail (Global News Wire from Financial Times)
Daily Mail (Knight Ridder/Tribune Business News from Knight Ridder/Tribune Business News)
Daily Mail (London) (RDS Business & Industry Database from Responsive Database Services, Inc.)
Daily Post (Liverpool)
Daily Post (Liverpool, England) (Marketing and Advertising Reference Service from Information Access Company)
Daily Record & Sunday Mail
Daily Record (Glasgow, Scotland) (Marketing and Advertising Reference Service from Information Access Company)
The Daily Star
The Daily/Sunday Telegraph (London)
The Daily Telegraph (Global News Wire from Financial Times)
Daily Telegraph (Marketing and Advertising Reference Service from Information Access Company)
Daily Telegraph (Overview of Markets & Technology from Information Access Company)
Derby Evening Telegraph
Derby Evening Telegraph (Northcliffe Newspapers)
The Dominion (Global News Wire from Financial Times)
The Economist
Economist.com
Energy Day
The European (Knight Ridder/Tribune Business News from Knight Ridder/Tribune Business News)
Evening Chronicle (Newcastle,UK)
× Evening Herald (Plymouth) ×
Evening Herald (Plymouth) (Northcliffe Newspapers)
Evening News (Edinburgh)
The Evening Post (Global News Wire from Financial Times)
Evening Standard (Europe Intelligence Wire from FT Information LTD.)
Evening Standard (Global News Wire from Financial Times)
Evening Standard (Knight Ridder/Tribune Business News from Knight Ridder/Tribune Business News)
The Evening Standard (London)
The Evening Standard (London, England) (ASAPII Database from Information Access Company)
The Evening Standard (London, England) (Marketing and Advertising Reference Service from Information Access Company)
Evening Standard (London) (RDS Business & Industry Database from Responsive Database Services, Inc.)
Evening Times - Glasgow
Exchange (IAC (SM) Newsletter Database (TM) from Information Access Company)
The Express
Express & Echo (Exeter)
Express & Echo (Exeter) (Northcliffe Newspapers)
The Express (Europe Intelligence Wire from FT Information LTD.)
The Express (Global News Wire from Financial Times)
The Express on Saturday (Europe Intelligence Wire from FT Information LTD.)
The Express on Sunday (Europe Intelligence Wire from FT Information LTD.)
The Express On Sunday (Global News Wire from Financial Times)
The Financial Gazette (Global News Wire from Financial Times)
Financial Mail on Sunday (London) (RDS Business & Industry Database from Responsive Database Services, Inc.)
Financial News
The Financial News (Global News Wire from Financial Times)
Financial Times (London)
Financial Times (UK) (India Business Insight Database)
Gateshead Post (UK)
The Gleaner (Global News Wire from Financial Times)
The Gloucester Citizen
The Gloucester Citizen (Northcliffe Newspapers)
Gloucestershire Echo
Gloucestershire Echo (Northcliffe Newspapers)
Grimsby Evening Telegraph
Grimsby Evening Telegraph (Northcliffe Newspapers)
The Grocer
The Grocer (Europe Intelligence Wire from FT Information LTD.)
The Guardian (Europe Intelligence Wire from FT Information LTD.)

- The Guardian (Global News Wire from Financial Times)
The Guardian (London)
 The Guardian (Overview of Markets & Technology from Information Access Company)
 Herald & Post (UK)
 ✕ Herald Express (Torquay) ✕
 Herald Express (Torquay) (Northcliffe Newspapers)
The Herald (Glasgow)
 The Herald (United Kingdom) (Europe Intelligence Wire from FT Information LTD.)
 The Herald (United Kingdom) (Global News Wire from Financial Times)
Hull Daily Mail
 Hull Daily Mail (Global News Wire from Financial Times)
 Hull Daily Mail (Northcliffe Newspapers)
The Independent and Independent on Sunday (London)
 The Independent (Europe Intelligence Wire from FT Information LTD.)
 The Independent (Global News Wire from Financial Times)
 Independent on Sunday (Europe Intelligence Wire from FT Information LTD.)
 Independent on Sunday (Global News Wire from Financial Times)
 The Independent (Overview of Markets & Technology from Information Access Company)
 Information World Review
 Insurance Day
 International Financial Adviser
 Investment Adviser
 Irish Independent (Europe Intelligence Wire from FT Information LTD.)
 Irish Independent (Global News Wire from Financial Times)
Irish News
 The Irish Times
 Irish Times (Europe Intelligence Wire from FT Information LTD.)
 Irish Times (Global News Wire from Financial Times)
 Irish Times (Overview of Markets & Technology from Information Access Company)
 The Journal (Newcastle, UK)
Leicester Mercury
 Leicester Mercury (Global News Wire from Financial Times)
 Leicester Mercury (Northcliffe Newspapers)
Liverpool Echo
 Lloyd's List
 Lloyd's List (Europe Intelligence Wire from FT Information LTD.)
The Mail on Sunday (United Kingdom) (Europe Intelligence Wire from FT Information LTD.)
 The Mail on Sunday (United Kingdom) (Global News Wire from Financial Times)
Manchester Evening News
 ✕ Manchester Guardian Weekly ✕
 Midland Independent Newspapers (Group Source)
 Mid Week Pink
 The Mirror (London, England) (Marketing and Advertising Reference Service from Information Access Company)
The Mirror (The Daily Mirror and The Sunday Mirror)
 Morning Star
 Network News
 Network News (VNU Business Publications from VNU Business Publications Ltd.)
The News of the World
 Northcliffe Newspapers
The Northern Echo
 The Northern Echo (Europe Intelligence Wire from FT Information LTD.)
 The Northern Echo (Global News Wire from Financial Times)
Nottingham Evening Post
 Nottingham Evening Post (Global News Wire from Financial Times)
 Nottingham Evening Post (Northcliffe Newspapers)
The Observer
 The Observer (Global News Wire from Financial Times)
 Off Licence News
 Off Licence News (Europe Intelligence Wire from FT Information LTD.)
 The People
 The Pink
Racing Post
 The Racing Post (London, England) (Marketing and Advertising Reference Service from Information Access Company)
 Regional Independent Media
Scotland on Sunday (Edinburgh, Scotland) (Marketing and Advertising Reference Service from Information Access Company)
 Scotland on Sunday (Global News Wire from Financial Times)
The Scotsman & Scotland on Sunday
 The Scotsman (Europe Intelligence Wire from FT Information LTD.)
 The Scotsman (Global News Wire from Financial Times)
 Scotsman (The) (Marketing and Advertising Reference Service from Information Access Company)
 Scunthorpe Evening Telegraph
 Scunthorpe Evening Telegraph (Northcliffe Newspapers)
 Selected UK News Stories (Group Source)
 ♦The Sentinel (Stoke)
 The Sentinel (Stoke) (Northcliffe Newspapers)
South Wales Echo
 South Wales Echo (Cardiff, Wales) (Marketing and Advertising Reference Service from Information Access Company)
 South Wales Evening Post
 South Wales Evening Post (Northcliffe Newspapers)
 Sports Argus
 The Stage
The Sun
 Sunday Business Post (Europe Intelligence Wire from FT Information LTD.)
 Sunday Business Post (Global News Wire from Financial Times)
 The Sunday Express
 Sunday Express (Europe Intelligence Wire from FT Information LTD.)
Sunday Herald

The Sunday Independent - Ireland (Global News Wire from Financial Times)

Sunday Life

Sunday Mercury

The Sunday Telegraph - United Kingdom (Europe Intelligence Wire from FT Information LTD.)

The Sunday Telegraph - United Kingdom (Global News Wire from Financial Times)

The Sunday Times (United Kingdom) (Europe Intelligence Wire from FT Information LTD.)

The Sunday Times - United Kingdom (Global News Wire from Financial Times)

Sunday Tribune

TelecomWorldWire (M2 Communications from M2 Communications, Ltd.)

The Times and Sunday Times (London)

The Times (Global News Wire from Financial Times)

The Times (London) (Europe Intelligence Wire from FT Information LTD.)

Times (London, UK) (Overview of Markets & Technology from Information Access Company)

UK Nationals Group File, Most Recent 90 Days (Group Source)

UK Newspapers Group File, Most Recent 90 Days (Group Source)

UK Newspaper Stories (Group Source)

UK Newsquest Regional Press - This is Hampshire

UK Publications Group File, Most Recent 90 Days (Group Source)

UK Publications (Group Source)

VNU Business Publications

Wales on Sunday

Western Daily Press

Western Daily Press (Global News Wire from Financial Times)

The Western Mail

Western Mail (Cardiff, Wales) (Marketing and Advertising Reference Service from Information Access Company)

Western Morning News (Global News Wire from Financial Times)

Western Morning News (Northcliffe Newspapers)

Western Morning News (Plymouth, UK)

Worldwide Computer Product News (M2 Communications from M2 Communications, Ltd.)

Yorkshire Evening Post

Yorkshire Post

Yorkshire Post (Europe Intelligence Wire from FT Information LTD.)

Yorkshire Post (Global News Wire from Financial Times)

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