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**“To die peacefully without pain...I want the right to have that choice!”:**

**Discursive Constructions of Euthanasia in the Aotearoa New Zealand Media**

A thesis presented in partial fulfilment  
of the requirements for the degree of

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## Abstract

This paper drew on Foucauldian understandings to analyse and critique the construction of euthanasia in the mainstream Aotearoa New Zealand media and what the media portrayal of euthanasia made possible for people to think, feel and do. The analysis involved a review of 45 articles published in early 2018 and the responses to a subset of 6 articles that were made open for reader comments. Analysis identified dominant discursive formations related to a particularly Western and individualised notion of ‘autonomy’. Euthanasia was represented as ‘right’ and much needed ‘choice’ to alleviate fear of future pain and suffering and fear of dependence on others. People and institutions supporting euthanasia were portrayed as heroes and martyrs and those against as villains. A terminal condition was not a prerequisite to legitimate euthanasia in the media. Resistance to the dominant formations rested on understandings that positioned euthanasia as dangerous for society and a not a real choice when people do not have equitable access to choices in life; and unnecessary if people could access palliative healthcare. Absent was any consideration of non-Western understandings of death and dying, and religious and spiritual understandings of dying were marginalised. These conclusions suggest diverse socio-cultural understandings of euthanasia are lacking in the media, and as such, future euthanasia legislation could be harmful to non-dominant cultures and groups living in Aotearoa New Zealand.

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“Just as I shall select my ship when I am about to go on a voyage, or my house when I propose to take a residence, so I shall choose my death when I am about to depart from life”.

Seneca, Letter 70. On the proper time to slip the cable.

(Seneca, c.65 AD, trans, 2016)

## Chapter 1: Introduction and Contextual Influences

Dying by euthanasia is a contentious and complex issue with a long history crossing philosophical, ethical, moral, legal, religious, medical, economic and cultural boundaries. The term euthanasia derives from the Greek word “Eu” meaning “easy” or “good” and “Thanatos” meaning death (“Euthanasia”, 2018). With this understanding, one might assume all people would desire this easy or good end to life, however, meaning is always contested and shaped by history and social context, and thus, it is not so. For example, two thousand years ago Seneca, the Roman Stoic philosopher (quoted on page vii), viewed euthanasia as a pragmatic action taken to avoid suffering in old age (Ryan, Morgan, & Lyons, 2011), whereas today people may associate euthanasia with the Nazi euthanasia program, Aktion T4<sup>1</sup>, whereby disabled children and adult psychiatric patients were murdered, and accordingly, view euthanasia as inducing suffering (Hohendorf, 2016).

Broadly speaking, present-day understandings of euthanasia are positioned as two sides of a coin, those in favour of legalising the practice, and those against. The debates are briefly sketched out here in order to provide context for the later analysis and discussion which considers how the media<sup>2</sup> limits our understanding by attending to some aspects of the debate in favour of others. Pro-euthanasia arguments relate to the following: the right to choose when, where and how to die; respect for autonomy/self-determination; ending pain and suffering; and public support for legalisation (Battin, 2005). Arguments for euthanasia also relate to quality

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<sup>1</sup> “Action T4” was the name of Hitler’s program which legitimised killing of thousands of people who fit the category ‘life unworthy of life’, those without usefulness to society, in the name of ‘release from suffering’ (Hohendorf, 2016).

<sup>2</sup> The words media, news, press, newspaper and press are used interchangeably and they can mean print or online publications.

of life over length of life; a desire to reduce reliance on medical life sustaining systems; preserving dignity in the dying process; eliminating legal jeopardy for health professionals; families and loved ones; and making covert practices transparent (Harris, Richard, & Khanna, 2006; Quill, 2008; Ruler, 2011). Conversely, opponents argue that people who may be vulnerable need protection from coercive practices; legalising euthanasia leads to the extension of eligibility criteria (commonly expressed as the ‘slippery slope’ argument); life has inherent sacred value (often presented as the ‘sanctity of life’ argument); and laws should not be changed for a small minority who desire euthanasia (Elliot, 2018; Keown, 1995). Arguments against also relate to the practice of hastening death being antithetical with medicine’s purpose to cure; there is a risk of wrongful death due to diagnostic errors; pain is manageable with appropriate palliative care; and legalising euthanasia reduces motivation to fund research and best practice treatments (Garcia, 2007; Pereira, 2011). These arguments are commonly presented in this dichotomous way, although there are alternative understandings that take some middle ground or a position of compromise. While each of the arguments is recognised as having merit in its own right, and both sides of the debate are unpacked and necessarily inform this work, it is not the intention to explore the debates in detail here. Instead, taking a critical perspective, this work considers the social construction of euthanasia in the Aotearoa New Zealand media, and what this construction makes possible for us to think, feel, and do in relation to this complex social phenomenon.

Few people have experience of dying, and even less with euthanasia, and as such, mediated sources are particularly influential in shaping perceptions (Somerville, 2001) and providing the context through which readers see the world, and gain knowledge about health, illness, and dying (Lyons, 2000). Within Aotearoa New Zealand, Bills relating to legalising euthanasia have been raised four times since 1995 (Borissenko, 2015). This includes a proposal to legalise euthanasia which is currently under consideration in Aotearoa New Zealand, so in

light of this, it can be assumed that the heightened media focus is influencing people's perceptions on both sides of the debate.

The latest Bill, sponsored by David Seymour the leader of the political party ACT New Zealand, is known as the End of Life Choice Bill (EOLC Bill). This Bill aims to provide people with a terminal illness, or a grievous and irremediable medical condition an option to request assisted dying (euthanasia). In December 2017 it passed its first reading by the Aotearoa New Zealand government with a decisive margin, 76 to 44 against. A summary of the EOLC Bill eligibility criteria is located in Appendix A.

In Aotearoa New Zealand, over the past thirty years, a number of euthanasia related cases have been brought before the courts with the most recent being in 2018. This case involved the trial of Susan Austen for the charge of aiding and abetting Annmarie Treadwell to commit suicide. Treadwell was a member of the Wellington branch of Exit International, a pro-euthanasia advocacy group of which Austen was the chairwoman ("Daughter Knew", 2018). Austen was acquitted of the assisting suicide charge, but found guilty of importing Class C controlled drugs (the drugs required for euthanasia). Her defence rested on the assertion that she did not intend Treadwell to commit suicide, but to give Treadwell the means to control the timing of when her life ended ("Susan Austen trial verdict", 2018). This story and the progression of the EOLC Bill dominated the period analysed in this thesis, and as such are referred to extensively in the later analysis and discussion.

Media accounts are a site of power creation and distribution that do not neutrally reflect social reality; they are not objective accounts but crafted constructions that usually represent dominant perspectives and marginalise alternative views, so that we see more often the standpoints of socially powerful or privileged groups (Ott & Mack, 2010). As a practice, media

promote stories for ‘newsworthiness’<sup>3</sup> to sell news to their audiences. In the context of this thesis, this is important as media facilitates and constructs the conditions that make social policy, such as legalising euthanasia possible. Media is not only a content provider, but integral to navigating health issues and policy formation (Hodgetts & Chamberlain 2006, p. 318). As mentioned earlier, most people have limited experience with dying, assisted suicide and euthanasia, and are therefore particularly sensitive to the framing<sup>4</sup> and discourses<sup>5</sup> used by the media. To better understand these effects, it is necessary to clarify the key terms that are taken up in this research.

### **Euthanasia Terminology**

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Often euthanasia discourse and its terminology are underpinned by moral judgments about what can be valued, and what social practices are acceptable. For instance, the term physician-assisted suicide conveys the permissibility of medical assistance in end of life choices (Cherry, 2018). Hence, in the euthanasia space, particular terms are used in particular ways. This section provides an outline of euthanasia terminology and how euthanasia is understood here. This is done with the recognition that terms and classifications are not neutral but imbued with power, and that meanings are negotiable, open for redefinition, and may be understood differently in the future (Cooper & Thorogood, 2013).

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<sup>3</sup> Single quotation marks are used for certain words to denote their constructed or contested nature on their initial use. Thereafter, they are referred to without quotation marks for ease of reading in most instances.

<sup>4</sup> Media framing involves a process of selection that results in a partial view of phenomena and is said to be influenced by social norms and values, interest groups and the ideological or political orientations of journalists (Khosravini 2014).

<sup>5</sup> Discourse is broadly understood as a pattern of talk or text. More detail on how this term is taken up is located in Chapter 3.

Over forty years ago, Rachels (1975) put forward the distinction between ‘active euthanasia’ and ‘passive euthanasia’. Active euthanasia is the intentional hastening of a patient’s death, while passive euthanasia refers to the practice of hastening death by withdrawing or withholding medical treatment (Chao, 2002; Garrard & Wilkinson, 2005). In Aotearoa New Zealand, *intentionally* hastening death by withdrawing or withholding treatment, is illegal. However, passive euthanasia is not illegal, nor is the provision of analgesia to relieve suffering with the knowledge that life could be potentially shortened<sup>6</sup> (Coombs, 2016). In addition to the active/passive distinction, Chao (2002) lists three other categories commonly used in relation to euthanasia; ‘involuntary’, ‘non-voluntary’ and ‘voluntary’. Involuntary euthanasia is performed on a competent person without their consent and said to amount to ‘murder’ (Garrard & Wilkinson, 2005). Non-voluntary euthanasia, refers to the ending of life of an incompetent person, for example a comatose patient unable to give consent. Legislation in Belgium, Luxembourg and the Netherlands allows doctors to perform non-voluntary euthanasia on an incompetent person provided the patient stipulated their wishes in an Advance Euthanasia Directive at a time when they were competent, (Tomlinson & Stott, 2015). Thus, a legal form of non-voluntary euthanasia is practiced today in some jurisdictions. Voluntary euthanasia is the intentional act of hastening death as requested or agreed to by a competent person.

In this thesis, for the sake of clarity, the notion of euthanasia is used to refer to the *active and voluntary* ending of life of a competent person either by their own hand, medical person, family member or other nominated person. This meaning encapsulates other commonly associated terms, namely, physician-assisted suicide, assisted suicide and assisted dying and is differentiated from passive euthanasia, involuntary and non-voluntary euthanasia. In the

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<sup>6</sup> The provision of analgesia (such as morphine) to relieve suffering with the knowledge that life could be potentially shortened is known as the “doctrine/principle of double effect” (Coombs, 2016).

following discussion of euthanasia terminologies and literature, any deviation from this meaning will be made explicit. The next section explores mainstream research to unpack how euthanasia is constructed in the Aotearoa New Zealand media and provides context for this present study, while the section following unpacks the broader socio-cultural context in which euthanasia is embedded.

### **Mainstream Understandings of Euthanasia**

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Consideration of traditional or mainstream research that makes up everyday understanding provides insights into how euthanasia, as positioned within academic literature, is used by both journalists and euthanasia advocates to support the construction of persuasive arguments (Johnstone, 2016). Mainstream research relates to a philosophical paradigm that values positivism, objectivity, experimentation, is universalist, essentialist and focuses on ‘individual’ characteristics (Burr, 2015). Drawing on both empirical and theoretical research, where possible, reference is made to studies conducted in Aotearoa New Zealand, however, I necessarily draw on international research including that from jurisdictions where the practice is legal to provide critical insights and context as local research is limited.

**Support and opposition for euthanasia.** A considerable body of research has focussed on opinions, attitudes and the demographic factors of euthanasia supporters and opponents. Doctors purportedly showed less support for euthanasia than nurses who are said to be influenced by a close relationship with the dying person (Kouwenhoven et al., 2013), for instance a recent Aotearoa New Zealand survey claimed that between 30% - 37% of doctors and 67% of nurses supported euthanasia (Oliver, Wilson & Malpas 2017 p. 12), echoing an international trend. In other research a philosophical orientation toward the preservation of life and religiosity were cited as the main influences on health professionals opposition to euthanasia (Emanuel, Onwuteaka-Philipsen, Urwin, & Cohen, 2016; Löfmark et al., 2008;

Pedersen & Tariman, 2018; Seale, 2009). Both international and local studies (e.g. see, Emanuel et al., 2016; Rae, Johnson, & Malpas, 2015) reported that the public consistently demonstrated higher support for euthanasia than doctors and patients.

Public support for euthanasia was said to be most influenced by concerns about pain and unbearable suffering along with increasing secularisation (Danyliv & O'Neill, 2015; Hendry et al., 2012; Rae et al., 2015), while opposition was strongly associated with religious beliefs (Danyliv & O'Neill, 2015; Hendry et al., 2012; Rae et al., 2015; Young, Egan, Walker, Graham-DeMello, & Jackson, 2018). One way that such support is demonstrated is through the media reporting of opinion polls.

Polls conducted on behalf of lobby groups make their way into media articles to highlight public support or opposition for euthanasia. However, often these results are skewed to fit political agendas as put forward by particular media, person or interest group. For example, in a local newspaper it was reported that 75% of people support medically-assisted dying for the terminally ill *and* those with unbearable irremediable suffering (Hurley & Burr, 2018). Yet, on closer inspection of the poll, only 66% supported medically-assisted dying in the case of unbearable irremediable suffering, and the 75% related to medically-assisted dying only for the terminally ill ("75% Support"). Academic researchers also draw from opinion poll data. For example, synthesising the results of 15 local public opinion polls/surveys over an 18 year period, researchers claimed that endorsement for euthanasia in Aotearoa New Zealand has been stable across time with a weighted average of support at 68.3%, opposition at 14.9%, and 15.7% unsure (Young et al., 2018). Often polling results as presented in the media or research are decontextualised and ignore cultural differences between people and countries, and material issues such as access to universal health care (this is discussed more in Chapter Five).

Other methodological concerns relate to data collection strategies used in opinion polls. Rose and Osbourne (1999) posit public opinion is commonly understood as the collective

views of the ‘rational individual’ and that opinion polls are taken up to represent ‘social facts discovered’ via the polling process (Rose & Osborne, 1999). Furthermore, standard sampling practices likely result in a sample whereby the majority of respondents are healthy, and as such, polling of participants relies on their hypothetical understandings of what it means to be considering end of life choices. Additionally, studies that rely on hypothetical understandings and responses to hypothetical vignettes fail to capture the complexity of euthanasia. All of these issues are important to consider as the media has a propensity to report opinion polls and other research tools and findings uncritically, as a social fact, and social policies are more likely to be implemented if “policy makers consider there to be sufficient public support expressed through media coverage” (Hodgetts & Chamberlain, 2006, p. 318).

It is claimed generally, that most euthanasia supporters are white, male, younger, able-bodied and religiously unaffiliated (Emanuel et al., 2016). This raises an interesting point as the demographic characteristics of euthanised patients translate similarly, in that they are mostly white, male, educated and religiously unaffiliated (Hedberg & New, 2017). While mainstream research describes these characteristics, it tends to affix this finding to the demographic characteristic and do no more. Troubling taken-for-granted understandings and unpacking how they matter is necessary as is consideration of the role media discourse plays in influencing the behaviour of these so-called supporters of euthanasia.

While the aforementioned research seemingly tells us something about how many people support/oppose euthanasia and what ‘type’ of person this might be, the research suffers from multiple issues of validity and reliability such as reporting bias, framing and temporal effects (for a review see Emanuel et.al, 2016). Moreover, it risks treating groups as homogenous, ignoring intersectionality, such as broader socio-economic influences that might matter to a person’s understanding of euthanasia. With this in mind, we move now from

reviewing the mainstream research related to support and opposition for euthanasia to consider what sits behind people's desire for euthanasia.

**Motivations for euthanasia.** In an attempt to make sense of the desire for euthanasia, mainstream research focussed on psychological motivations and social influences. 'Unbearable suffering' appeared to be a psychological concern. One synthesis of 16 qualitative studies broadly defined unbearable suffering as including the notions of "loss of self, dependency and burden" (Hendry et al., 2012, p. 23). Yet, another review of 55 primarily Dutch and American studies noted that 90 motivations underpinned the construct of unbearable suffering, with researchers positing it was a profoundly personal and subjective experience with no generally accepted understanding (Dees, Ñ, Vernooij-dassen, Dekkers, & Weel, 2010). The many and varied meanings of unbearable suffering pose a challenge to the traditional doctor/patient relationship, whereby objective criterion is the preferred medical standard on which to make health related decisions, whereas unbearable suffering relies upon a patient's subjective standard. The construct of unbearable suffering may similarly pose challenges to the doctor/patient relationship in Aotearoa New Zealand if the proposed EOLC legislation with its criteria of unbearable suffering is made law.

The notion of fear featured regularly in studies. Fear of pain was said to significantly inform a patient's desire to end life, more often than the experience of pain itself (Hendry et al., 2012). In a local study, it was surmised that participants feared a future of (perceived) incapacity, fear of being a burden on others and society, and feared losing their independence (Malpas, Mitchell, & Johnson, 2012). While these are important insights, this research appears to take for granted concerns around disability, burden and dependency. For example, the authors did not acknowledge that the issue of dependency on others to assist with daily living activities such as toileting and personal care is a problem only when cultural context decrees dependence as abnormal (Borgstrom & Walter, 2015; Pace & Grenier, 2016). Lawton (1998)

proposed that a physically bounded body intolerant of disintegration and bodily emissions is a particularly Western contemporary understanding of the ‘self’, not seen in other cultures, yet mainstream research has rarely attended to cultural nuances that have implications for the desire for euthanasia.

While the general public most often cited ineffective pain management as the primary reason to support legalising euthanasia, for patients, research indicated pain was not the main reason for the desire to end life (Emanuel et al., 2016). Reviewing 20 years of Oregon data, Hedberg and New (2017) concluded that most patients (91%) cited a loss of ‘autonomy’ as the most prevalent motivation behind their desire for euthanasia (Hedberg & New, 2017 p. 580). Data from Canada and Europe showed similar findings (Emanuel et al., 2016). However, it is unknown if loss of autonomy referred to concerns of medical paternalism, or non-medical issues such as insufficient assistance with daily living activities, or indeed what autonomy meant at all as this term was not clarified in the research.

Although there are many forms of ‘autonomy’ mainstream research does not attend to variants such as emotional, relational or supported autonomy (these are discussed further in Chapter Five). It typically draws on dominant understandings of a ‘Western’ form of autonomy based on an individualistic notion of self-determination (Van Brussel, 2014). While most of the euthanasia research attends to the ‘individual’, some research has focussed on broader societal concerns arounds risks to ‘vulnerable people’, and this is considered next.

**People who are vulnerable.** Proving or disproving evidence that vulnerable people are disproportionately negatively affected by euthanasia legalisation was the focus of much research. In mainstream studies, vulnerable people are typically categorised by sociodemographic status, for example, the elderly, women, low educational status, uninsured people, ethnic minorities, or other categories such as people with non-terminal disabilities, and mental illness. In places where euthanasia and physician-assisted suicide are legal, it was

claimed that vulnerable people have not been negatively influenced by euthanasia laws (Emanuel et al., 2016). Reviewing twenty years of Oregon data, the median age of euthanised patients was 72 years, 52% were men, 96% identified as white, and 72% had some college or higher education with researchers claiming that risks associated with low socioeconomic status have not borne out (Hedberg & New, 2017). Ninety-six percent of euthanised patients identified as “white” in the aforementioned research, which suggests there is much to know about experiences of euthanasia for non-white people and vulnerability, yet research on such groups is scant.

The traditional understanding of vulnerability in the previously mentioned studies ascribed labels to certain groups such as the ‘poor’, ‘uneducated’, or the ‘older female’ who shared characteristics as a way to categorise groups at a sub population level. While this is the commonly understood approach in mainstream research, this thesis follows the thinking as argued by Luna (2009) that the notion of vulnerability is “layered and dynamic[with] no single feature that in and of itself defines vulnerability or explains it entirely...rather it is particular contexts and situations that make or render someone vulnerable” (pp. 128-129). In this sense, vulnerability is inessential and not fixed to a person because of certain characteristics. For example, a woman who is older in age is not vulnerable to coercion of euthanasia because she is an older woman, but she might be rendered vulnerable by a “socialised reluctance to be a burden” (Tulloch, 2015 p. 116) , or because she experiences short-term financial challenges. Conceptualising vulnerability as layered and dynamic invites reflection by people not usually labelled vulnerable. For instance, white, older, middle class, educated males who take up the practice of euthanasia can also be positioned as vulnerable due to socialised expectations to be masculine, strong and healthy (Courtenay, 2000). The next three subsections unpack how mainstream knowledge understands the association of euthanasia with suicide and ‘mental

illness' and attends to various moral, ethical and cultural influences and how they matter to what we can know about euthanasia.

**Mental illness, suicide, and euthanasia.** A number of complexities become apparent when considering the association of mental illness with suicide and euthanasia. 'Serious mental illnesses' are exclusionary criteria in most jurisdictions where euthanasia is legal (Vulcănescu, 2018) and clinical depression was singled out in euthanasia research that alleged dramatic decreases in desire for euthanasia occurred for patients who responded to antidepressant treatment (Breitbart et al., 2000; Breitbart et al., 2010). The desire to die for those experiencing mental illness is commonly viewed as irrational and inauthentic, and therefore cannot be a competent or coherent choice (Hewitt, 2013).

There have been some challenges to the conclusions drawn about whether those with mental illness have received euthanasia at higher rates than the general public. There is an assumption that cases of depression are missed in primary health care making it possible that some people have an undiagnosed mental illness but receive euthanasia regardless (Battin, van der Heide, Ganzini, van der Wal, & Onwuteaka-Philipsen, 2007; Finlay & George, 2011; Hedberg & New, 2017). Critical research contends 'depression' is itself a contested category whose classification and assessment criteria changes every 30 years, and that the term only came into common use in the 1960s around the same period anti-depressants were marketed to the public (Davis, 2013). These issues are important to consider as they matter to how eligibility for euthanasia is constructed in the media.

While some critical researchers argue that concepts of suicide and euthanasia are "bound together historically and share similar moral arguments" (Ryan et al., 2011, p. 45) it is more common place for sharp distinctions to be drawn in mainstream research. Suicide is predominantly painted as irrational and the result of a psychiatric illness, choosing death by suicide is seen as impulsive, violent and causing considerable destruction to the body, whereas

euthanasia is portrayed as the product of rational, autonomous, independent people empowered to control the end of life (den Hartogh, 2016; Gillett, 2017).

**The Church and Medicine.** While there is extensive research quantifying the opposition to euthanasia on religious or medical ethical grounds, less research has focused on the moral and ethical considerations that underpinned the reported numbers. Religious or spiritual opposition was said to stem from religious doctrine, a belief that ‘God’ decides the time of death, a religious duty to live, and the sanctity of life (Malpas, Wilson, Rae, & Johnson, 2014; Sheahan, 2016; Wilson et al., 2007). However, the aforementioned studies drew on hegemonic Christian understandings of religion and ignored the wide degree of heterogeneity observed within religions, and across religions, as noted in more recent research (see for example, Chakraborty et al., 2017).

**Cultural influences.** Research exploring what euthanasia means to non-dominant cultural groups, such as Māori, the tangata whenua<sup>7</sup> of Aotearoa New Zealand, is limited in both mainstream and critically oriented studies. Of the mainstream research that exists, culture is predominantly conceptualised in terms of ethnicity and takes the form of attitudinal surveys. For example, a local study by Rae, Johnson and Malpas (2015) determined ethnicity had little predictive power in attitudes towards support or opposition to euthanasia. In other research, it was claimed Pasifika and Asian groups were significantly less supportive of euthanasia than Māori or New Zealand Europeans (Young et al., 2018).

**Reflection on the mainstream research paradigm.** Falling within an essentialist research paradigm, the aforementioned studies seemingly tell us something about the opinions, attitudes, demographic characteristics, motivations and meanings ascribed by people and taken

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<sup>7</sup> The Māori kupu (words) referenced translate as tangata whenua being the people of the land, iwi are Māori tribes and kaumātua Māori elders, wairua is spirit and wairuatanga spirituality, kawa refers to protocol and etiquette, and whānau means extended family or community (Malpas et al., 2017a).

up in the media as if research can explicate and ‘measure’ the inner workings of the mind. Results are rarely questioned, and more often considered common sense. Critically, these studies mostly ignored wider social forces that shaped and contextualised the subjective experience and the connections to euthanasia.

Mainstream analysis favoured a Western individualised notion of a ‘self’, while non-Western values such as interdependence, reciprocity, and kinship (Lamb, 2014; Ranzijn, 2010) and holistic perspectives of health, incorporating familial, social and spiritual aspects were mostly ignored. Accordingly, privileging Western values and perspectives provides only a partial understanding of euthanasia. Furthermore, studies conducted from non-indigenous frames likely affect the interpretation of the findings in relation to cultural influences. To illustrate how a non-Western perspective enriches how we can know euthanasia, a local study undertaken by Malpas et al. (2017a) of Kaumātua views using a kaupapa Māori research design<sup>8</sup> is briefly explored. In this research, concerns about euthanasia were primarily related to the disruption of the dying process for the wairua and the importance of kawa for the dying person and their whanau, thus aspects of wairuatanga and cultural practices informed the meaning of euthanasia. Moreover, the centrality of the whānau to hold collective responsibility for medical decision-making was highlighted. In light of the EOLC Bill, this is important as the Bill allows a person to request euthanasia without the knowledge of their family; therefore, what it means to live in a collective culture where decisions about life and death are shared by the whānau is purportedly missing from the proposed legislation (Turia, 2019). Furthermore, according to aforementioned research by Malpas et al. (2017a), just as some iwi practiced euthanasia in the recent past<sup>9</sup> and some did not, in contemporary Aotearoa New Zealand some

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<sup>8</sup> Kaupapa research is research based on Māori paradigms, customs and protocols (Malpas et al., 2017b).

<sup>9</sup> In some iwi, a specialist sat a dying person up and broke the neck to hasten death (Malpas et al., 2017a).

Kaumātua viewed euthanasia negatively and an erosion of cultural practices, and others viewed it more favourably as a ‘human right’. These differences in Māori perspectives also play out in the media with some Māori arguing euthanasia is culturally foreign to Māori (Stephens, 2016), and others, such as Paraone Gloyne positing tikanga was created according to what was needed at the time, and that *tuku wairua*, (to free one’s spirit) is an example of euthanasia (Taumata, 2017). Both the divergent historical and contemporary views highlight the heterogeneity of Māori understandings of euthanasia, and remind us of the importance to consider historical and cultural specificity beyond demographic characteristics such as race or ethnicity.

Criticisms aside, it is helpful to have an overview of the key research themes and findings from which everyday dominant understandings and media representations are taken. Moving ahead, in order to situate this thesis, the next section considers the legal and broader socio-cultural context that influences how euthanasia is produced in the Aotearoa New Zealand media.

### **Contextual Influences of Neoliberalism, Ageing and Disability**

Clearly, how we come to ‘know’ euthanasia does not happen in isolation of other social, cultural and contextual factors. As such, how euthanasia is constructed in the media needs to be considered in the context of broader discourses and influences that make it possible to think of euthanasia as a potential end of life option today. Although many influences matter to euthanasia discourse, a discrete number of lenses were chosen to pay attention to; neoliberalism, ageing and ‘disability’. While my primary research question sought to understand how euthanasia was constructed in the Aotearoa New Zealand media, and what this meant in terms of what people can feel, think and do, I was also interested in the secondary questions of how neoliberal practices intersected in the production of euthanasia as an end of

life option and how the disabled, ageing, or dying body was perceived, negotiated, and/or reinforced.

Neoliberalism was chosen as a lens as it provides a framework for discussing how certain values impact upon health, illness, disease and dying, while ageing and disability were chosen because critical research claimed these terms were conflated by the media with the practice of euthanasia, thus devaluing the lives of older adults and disabled people (Haller & Ralph, 2001; McInerney, 2007; Schwartz & Lutfiyya, 2009). As all terms have multiple meanings, before proceeding, how disability is understood is first made clear. While the expression 'people with disabilities' is preferred by some members of the disability community as it puts people ahead of disability, for others, this is said to infer a pathological deficit and they prefer the expression 'disabled people' acknowledging that disability is the condition created by disabling practices (Oliver, 2013). There is no current consensus in Aotearoa New Zealand on the most appropriate phrase to use, and following the language used in the New Zealand Disability Strategy (Ministry of Social Development, 2016) the term 'disabled people' is used here and refers to people with impairments which can be mental, physical, or sensory, *and* who experience disabling barriers.

**Neoliberalism.** In the context of this thesis, how neoliberalism, and the construction of risk and fear intersect with personal responsibility for end of life choices is important and provides a wider context for how particular opinions, attitudes and motivations are shaped. While the study of neoliberalism is often constrained to the political-economic space, here I follow Foucault's thinking and view neoliberalism not as an economic ideology enforced by the elite on to the masses, but a set of values, ideas, policies and language that emerged to unsettle the State's authority over various aspects of people's lives (Flew, 2014).

Within the neoliberal ideologies functioning in Aotearoa New Zealand around the late 1970s, healthcare once funded by the State become increasingly privatised and responsibility

for health began to shift from the State to consumers (Bell, Elizabeth, McIntosh & Wynward, 2017). The shift from public to private responsibility for health was facilitated through the construction of a 'risk society' with the media regularly promoting stories about how to manage personal health risks (Petersen & Wilkinson, 2008), the emphasising of neoliberal values such as autonomy and choice (Clarke, 2005; Hausmann, 2004), and the promotion of a market economy. Managing risk in neoliberal society requires the generation of fear which calls upon subjects<sup>10</sup> to rationally weigh up the pros and cons of certain health practices (Beiling, 2006) and to choose practices that support the project of the 'healthy self' (Power & Polzer 2016).

The pro-euthanasia arguments of right to choose and respect for autonomy draw upon the neoliberal notion of 'freedom of choice'. When a subject is no longer able to perform the project of the healthy self through illness, disease, mental or physical decline, euthanasia is portrayed as a consumer choice between other various modes of dying, such as palliative care, a hospital death, and even suicide (Johnstone, 2016). According to Johnstone, the pro-euthanasia argument that promotes 'individual autonomy' over medical paternalism, positions euthanasia as a moral issue, not an economic issue, and in doing so, sidesteps concerns about the economic burden of a protracted dying process and ageing population. This subtly transfers the accountability for end of life decisions from the State and healthcare providers to the consumers of healthcare who bear full responsibility for the consequences.

**Ageing.** The relationship between age, healthy bodies and euthanasia is a strong one that plays out in the media. Aotearoa New Zealand is experiencing an ageing population due to lower birth rates, high numbers of those born between 1946 and 1964, and increasing longevity with medical advancements (Jackson & Cameron, 2017). These influences have

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<sup>10</sup> Subject is a term used to replace the notion of the 'individual' as a free, conscious, thinking agent not acted upon by cultural or historical circumstances (Burr, 2015).

coalesced to create a so-called ageing population which is a central problematic of contemporary government.

The dominant portrayal of ageing in the media is negative. Features including ‘frailty’ and ‘dependence’, the rising cost of health care, and the projected shortfall in retirement incomes are often emphasised with fear invoking headlines such as the following; “Here's why you need \$2m saved for a comfortable retirement” (Starks, 2018), a sum of money beyond the reach of most people. Coupled with dramatic metaphors such as silver tsunami or time bomb, this framing privileges youth over old age, and increases public concern about economic burden bestowed on society (Hurley, Breheny, & Tuffin, 2017). Ageism, which is taken here to mean a systematic stereotyping of and discrimination against people because they are old, is thus inherent in media discourse, with old people constructed as the problematic ‘Other’. Such discourses produce the aged body as an economic burden, and invoke euthanasia as the solution to the burdensome old person’s duty to die (Balch, 2017).

Contesting the negative framing of old age, alternative discourses like *healthy ageing*<sup>11</sup>, *positive ageing* and *successful ageing* appear less injurious. However, according to O’Rourke and Ceci (2013), these alternative discourses position older adults as responsible for their short-term health, and the avoidance of diseases commonly occurring in later life, such as dementia, diabetes and cardiovascular disease. These discourses give rise to a new norm that has ageing occurring without cognitive or functional decline. We cannot however ignore the materiality of ageing as it is an embodied change, and certain illnesses for older people, including multi morbidities such as cardiovascular disease and diabetes, are considered normal (Lyons and Chamberlain, 2006). These discourses can induce fear, as the alternative is a body that is *frail* or *dependent*. The healthy/positive/successful ageing discourses thus become a risk management strategy to ward off the process of ageing, and when illness or disease strikes,

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<sup>11</sup> Discourses noted in the media and in the academic research are italicised for emphasis.

euthanasia presents itself as a way to “avoid the anticipated and perceived corporeal grotesqueries of illness and ageing” (McInerney, 2007, p. 390).

**Disability.** Disability activists have fought hard against medical paternalism and are strong advocates for personal autonomy and control over their bodies, yet when it comes to the euthanasia debate, somewhat paradoxically, the majority of disability organisations are vocal in their opposition to legalising euthanasia (Davis 2015). Some of this opposition is based on using the euthanasia platform to highlight social and economic injustices, while others oppose euthanasia on moral arguments related to the intrinsic value of life. While these positions are important to the general debate, in the following analysis, I intend to focus on how living in an ableist society and the forces of normalisation intersect with disability and euthanasia. Ableist society here refers to the idea that society favours the non-disabled person over the disabled person who is problematised as abnormal, in need of surveillance and risk management, and Other to the healthy non-disabled norm (Saltes, 2013). This othering of disabled people extends to all categories of impairment, including mental illnesses, such as dementia and depression.

In summary, this chapter briefly outlined the two sides to the euthanasia debate and highlighted how this oppositional structure can limit understanding of alternative positions. An outline of the legal context has been provided and terminology related to the construct of euthanasia and certain cultural influences has also been considered. I have reflected on mainstream research and, without privileging mainstream knowledge, have shown how it can be of use in unpacking everyday understandings of euthanasia that is likely presented in the media. This chapter closed with deliberation of how the broader socio-cultural environment might impact upon the construction of euthanasia. We now turn to consider a body of literature emerging from critical research that took language and text as its epistemological underpinning, that is, what we can know about euthanasia - we learn through discourse.

## Chapter 2: Euthanasia in the Media through a Critical Lens

The turn to language and the study of discourse as a place where versions of reality are constructed was adopted by some psychologists in the late 1970s (Willig, 2001). Discourse analytical research on euthanasia in the field of psychology however is limited, and accordingly, the following studies draw from other disciplines and cover two decades of work. I have chosen to follow the lead of Potter and Wetherell (1995), and not to paint a sharp distinction between the different theoretical underpinnings of the studies, as they all share an interest in how language, text and discourse shapes our understanding of euthanasia.

This chapter first explores the construction of euthanasia in the media, it then looks at certain media and journalistic practices that support the development of euthanasia discourses, and closes with a review on what discourses were absent, oppressed, marginalised or silenced. As the main purpose of this thesis is to consider how euthanasia is constructed in the media and how this construction limits and enables our understanding of euthanasia, the proceeding studies are taken from research that utilised newspapers and magazine articles as their data source. As more differences than similarities exist between the studies, I present the discussion in this section in a chronological but integrated manner.

### Discourses in the Media

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**Choosing euthanasia.** Discourses surrounding choice vary in the way they are constructed in the media, although they share the arguments that euthanasia is a *voluntary choice* that is distinct from involuntary euthanasia, and that choice is opposite to the notion of coercion (Clarke, 2005; Hausmann, 2004). In a review of British newspaper articles, Hausmann (2004) noted the press implicitly positioned euthanasia as a *voluntary choice* resting on the notion that choice was the natural outcome of being “born with a right to choose” (Hausmann,

2004, p. 214). Moreover, being terminally ill was portrayed as justification for euthanasia, over and above the notion of choice, and social coercion was downplayed as euthanasia was constituted as the legitimate choice of the terminally ill. In cases where no terminal illness was present, the notion of criminality was called upon to denounce the practice. Hausmann argued choice is not natural, instead, choice is always contextual and the result of constructing others “as individuals with a right to choose” (p. 214).

In another study, this time analysing North American and Canadian magazine articles, Clarke (2005) found that euthanasia was produced as an exercising of a person’s right to choose a death of their liking, at a time of their choosing. According to Clarke the articles repeatedly emphasised death could and should be *under control*. Societal concern was related to the “degree to which death could be controlled and chosen” with a strong emphasis in “personal preference” and “individual freedom” in the way people died (Clarke, 2005, p. 162). Clarke challenged the notions of choice and control however, and claimed that characterising the control of death in this way obfuscated social and cultural issues and forms of inequality which precluded control of the circumstances and timing of death for most Americans. She also noted there was no portrayal of death as random, and therefore outside of any choice and control.

The association between choice and euthanasia was constructed differently again in the Australian press. Investigating Australian media representations of the Rights of the Terminally Ill Act<sup>12</sup> (ROTI Act), McInerney (2007) argued that the media produced euthanasia as a strategy to avoid illness and ageing so that people could confront the lack of control they had in stemming corporeal decay (the theme of corporeal decay is reviewed in a later subsection). Rather than associating choice with a natural birth right as noted in previous discourse

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<sup>12</sup> The ROTI Act legalised euthanasia in the Australian Northern Territory in 1995 before being overturned by Federal law in 1996. While it was legal, four people died by enacting its provisions (Nitschke & Stewart, 2011).

(Hausmann, 2004), choice in the Australian press was associated with the notion that beauty lay in the choice to request death.

**Autonomy, independence and dependence.** Both *autonomy* and *independence* are represented as dominant discourses by Birenbaum-Carmeli, Banerjee and Taylor (2006). Their analysis of media representations of family assisted suicide in Britain stated the press depicted people who enacted euthanasia as independent, strong-minded and determined with images suggesting an ‘autonomous individual’ who was courageous both in life and in death. On the flip side *dependence* was starkly contrasted with references that produced the deceased as bedridden, crippled, pain-racked, tired, distressed, confused and forgetful. Euthanasia was represented as freeing the “trapped self from a failing body” (p. 2157). Haller and Ralph (2001), found that in Great Britain and the United States euthanasia was equated with dependency; damage and defectiveness with disability; and disabled people were portrayed as being confined to their wheelchairs. The authors challenged independence as a reserve of the non-disabled, arguing that assistive technologies such as wheelchairs can be viewed as liberating and a continuation of independence for disabled people (Haller & Ralph, 2001).

**Individualistic culture, harmonious families, and expressions of neoliberal values.** Clarke (2005) noted that North American and Canadian media privileged stories and concerns about ‘individuals’ and their desire to determine when and how death should occur over the needs or concerns of the community. This emphasis favoured individualism by directing attention away from material and structural issues of social inequality and factors less agreeable to ‘individual’ freedom. That death might occur in families or communities was rarely considered by the media. A similar finding was noted by Birenbaum-Carmeli et al. (2006) who posited that although death by euthanasia likely affected a broad network, attention to family relations was virtually absent in the British press. If attended to at all, families were described as *harmonious and loving*, with idealistic portrayals of family relations and euthanasia

presented as a Foucauldian “technology of the self” (p. 2162) to be pursued to achieve certain states of self-development, such as happiness and perfection.

Birenbaum-Carmeli et al. (2006) found that people involved in the act of euthanasia were portrayed in the British press as embodying the neoliberal ideals of responsibility, enterprise, and entrepreneurialism. British law was construed as an oppressive state apparatus that failed its citizens, and family members who enacted euthanasia were constituted as dignified people trapped in an outdated legal system. Individualism was said to be depicted in images of “freethinking judges” (p. 2161) who were rendered compassionate ‘individuals’ who enterprisingly worked around bureaucratic rigidity by passing lenient sentences (Birenbaum-Carmeli et al., 2006). The next two subsections look at discourses of the body and how they intersect with euthanasia and the construction of the euthanasia death as an object of *beauty*.

**Corporeal decay and relief from pain and suffering.** McInerney (2007) alleged discourses in the Australian media of *aesthetics* and *embodiment* constructed euthanasia as a modern choice to escape an unendurable corporeal situation. Here, euthanasia was bound to terminating a progressively decaying body. While dying in hospitalised settings sequestered away from public view (Lyons & Chamberlain, 2006) has become the norm in Western countries, the ROTI Act provided the press with opportunities to depict explicit images of previously ‘hidden’ dying processes. Bodily decay was described with frequent references to lesions, pus, ulcers and the personal distress of changing colostomy bags. The images put forward by the Australian press conjured up a contemporary example of dying that was beyond the help of medicine, and one that challenged the absolute control of pain and suffering said to be available via palliative measures. Moreover, in a social context where bodily imperfections were not tolerated, a social response demanded euthanasia. The permanent arrest of corporeal decline through euthanasia was a way in which the dying body “attained or regained an admirable, desirable status: that of the autonomous, responsible, ‘healthy’ citizen” (McInerney

2007 p. 394). The discourses explored by McInerney (2007) differed from mainstream research that claimed fear of pain, and loss of autonomy were the most prevalent motivating factors for a patient's desire for euthanasia (Hedberg & New, 2017; Hendry et al., 2012). Instead, the motivations portrayed in the Australian media were associated with fear of failing bodies and broader social expectations around control of bodily emissions.

*Relief from pain and suffering* was used in the media as a frame to justify the actions of both health professionals (Hausmann, 2004), and perpetrators (Birenbaum-Carmeli et al., 2006; Schwartz & Lutfiyya, 2009) involved in the illegal act of euthanasia with frequent and dramatic bodily descriptions of the dying such as "pain-racked" and "crippled" bodies (Birenbaum-Carmeli et al., 2006, p. 2157). Furthermore, relief from the pain and suffering from *terminal illness* appeared superordinate to *choice* in Hausmann's (2004) research and was used to legitimate euthanasia.

**The 'Beautiful Death'**. In the Australian media, according to McInerney (2007), death by euthanasia was constructed as a beautiful release synonymous with the good death of ancient times that was painless and easy. The modern good death is argued to be a movement against a medicalised death and is a death that is planned for, an "aware death" that occurs before the "dissolution of the social bond" in the presence of loved ones (Seale, 1998, p. 183). In McInerney's analysis, as outlined earlier, beauty lay in the choice to request death. The construction of a *beautiful death* also lay in the media images of blissful visions of people lying around on sofas by the ocean, slipping off peacefully into death. One person's death was depicted as "joyous and physically transformative" (p. 391) which according to McInerney echoed Seale's (1998) *revivalist* discourse about "transformation of death into life" (Seale 1998 cited in McInerney, 2007, p. 391). Seale (1998) talks of the *revivalist* discourse as a way to address the emotional side of how we reflexively form self-identity and those that take up this discourse can view dying as a period of grieving whereby they participate in certain strategies

designed to engender hopeful and positive feelings of the dying experience. In the construction of the *beautiful death* no references were made to biomedical constructions of death, for example, the delivery of a lethal drug via an intravenous line into a blood vessel, and this McNerney (2007) argued had the effect of distancing the euthanasia debate from medical control of life. This finding supports other research such as that by Mishara and Weisstub (2013) who alleged potential complications from a euthanasia death such as long intervals between ingestion and death, or vomiting and muscles spasms are mostly ignored in the media, yet known to occur in up to 10% of euthanasia cases. The next subsection discusses the conflation between various social phenomena and euthanasia located in the media.

### **Conflation Between Social Phenomena**

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Two articles explored the representation of disability within euthanasia discourse noting the conflation of disability and terminal illness, and other critical issues such as how disabled bodies are viewed in the media. According to Haller and Ralph (2001) a discourse of *better off dead* than disabled was produced in the New York Times and The Guardian newspaper of Great Britain. While this may be considered as a bold claim, this discourse has been noted in other issues related to control of the disabled body (Barile, 2002; Reynolds, 2017). Haller and Ralph (2001) recognised that disability was represented by the press as medicalised and individualised, rather than structurally constructed phenomenon that failed to accommodate physically different people. Consequently, disability was reinforced as abnormal. Furthermore, the authors argued external factors such as the lack of access to assistive technologies or attendant services underpinned a disabled persons choice in favour of euthanasia. In the second study, Schwartz and Lutfiyya (2009), reviewed a Canadian news story about family assisted suicide. The authors claimed the press narrative presented a one-sided view that people with diseases faced “horrible futures”, and might be “better off dead” than living with an

impairment, producing disability as a “fate worse than death” which had the effect of encouraging death for disabled people (Schwartz & Lutfiyya 2009, p. 27). Similarly, to Haller and Ralph (2001), having a body outside of the norm was constituted as unacceptable.

As mentioned previously, conflation of disability and terminal illness was seen in both studies. Disabled people were characterised as “seriously ill” and much attention was made to their various ailments, although these people were in fact not terminally ill which was not made clear (Haller & Ralph, 2001, p. 415). Moreover, the person at the centre of the Canadian stories was presented as terminal yet was not terminal, at an advanced stage of disease, nor near the end of life but living with a chronic and disabling disease (Schwartz & Lutfiyya, 2009).

Conflation between social phenomena was also seen between old age, illness and euthanasia. In the Australian media, older adults bodies were represented similarly to the terminally ill and depicted as “ugly, horrifying and incompatible with life” (McInerney, 2007, p. 390). Press images of residential aged care facilities conjured up images of people who had no useful or productive purpose in life, and had lost their so-called personality. This discourse of *aesthetics* and *embodiment* was seen by McInerney to overlap with calls to justify exiting older people past their “use-by-date” (p. 390) and positioned them as the problematic Other and euthanasia as the solution for old age.

In summary, this section explored the variety of euthanasia discourses as represented in the media across different social and historical contexts. The variances in how certain notions were taken up, for example, the discourse of *choice* and its many meanings underscored the complexities inherent in how language, text and discourses shape our understanding of euthanasia. In a number of these studies neoliberal influences were said to support the euthanasia discourse, including the notions of freedom of choice (Hausmann, 2004) responsibility, enterprise and entrepreneurialism (Birenbaum-Carmeli et al., 2006). The notion of autonomy and independence when counterpoised with dependence highlighted the media’s

privileging of lives lived independently as the norm (Birenbaum-Carmeli et al., 2006; Haller & Ralph, 2001; Schwartz & Lutfiyya, 2009). In two studies, death by euthanasia was primarily constructed as a way to stem physical decay and decline (Birenbaum-Carmeli et al., 2006; McInerney Fran, 2007). Finally, terminal illness, ageing, disability and illness were conflated in various studies which had the effect of presenting euthanasia as a solution for all social phenomena (Haller & Ralph, 2001; McInerney Fran, 2007; Schwartz & Lutfiyya, 2009). The next section discusses the use of certain rhetorical devices and other media practices that inform the construction of euthanasia discourses.

### **Media and Journalistic Practices**

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As well as the media representation of euthanasia discourses as discussed above, the institution of media is influenced by its own editorial and journalistic practices and the need to create a saleable commodity. As such, it relies on certain methods to generate interesting content for readers to engage with. One method is that of storytelling which persuades and influences people through the use of narrative characters such as victims, villains, and heroes. This also evokes emotions media audiences are supposed to feel towards the various actors (Jasper, Young, & Zuern, 2018). At a basic level, we pity victims, fear and occasionally hate villains, and admire heroes. Other media practices include the use of drama and tragedy to entertain, and gate keeping and agenda setting whereby editorial boards and journalists control what gets published (Ott & Mack, 2010). Drawing predominantly upon the research already explored in the section above, the following illustrates how various practices and methods were used in the media to construct euthanasia.

**Storytelling: Heroes, martyrs and villains.** The hero and martyr theme played strongly across many of the studies and was aligned to a pro-euthanasia stance. Birenbaum-Carmeli et al., (2006) found that character descriptions of those dying by euthanasia typically

suggested they were courageous in life and death. The researchers contended such framings portrayed *tragic heroes*, grappling with the ravages of both disease and modern State bureaucracy. McInerney (2006) similarly found a prevailing heroic discourse with the terminally ill positioned as *heroic victims* of their bodies and diseases. In highly personalised accounts, the dying became fearless, brave, altruistic, and martyrs for the cause of euthanasia. It was claimed that alongside the portrayal of the dying as *victorious* and *heroic*, there was no possibility that a person could be a victim of their body and disease, and be a hero for not choosing euthanasia. Locally, coverage in the Aotearoa New Zealand media depicted Lecretia Seales as a *hero against the legal system* for the right to end her life with the support of a doctor, and also a *martyr* for the way she acted for the “betterment of all New Zealanders” (Revell-Dennett, 2018, p. 170). The hero status was not only reserved for the dying however, other people were also constituted as heroes in the euthanasia discourses.

Family members who assisted in the euthanasia of the deceased were hailed as heroes. In one Canadian study, Marielle Houle, a mother who helped her disabled son commit suicide was represented as an *heroic mother* (Schwartz & Lutfiyya, 2009). Following the trial of Houle<sup>13</sup>, researchers found that although assisting suicide was illegal, the media did not depict her as someone who committed a criminal act. Instead, Houle was described as devoted, courageous, a crusader, and her actions as symbolic of great love. Interestingly, her lawyer denied Houle viewed herself as a *martyr*, however, in doing, readers were said to be reminded that is what she was. Other research similarly noted that the press portrayed the assistance of family members in the act of euthanasia as merciful and a demonstration of great love, and claimed the press favoured a heroic narrative in order to create drama (Birenbaum-Carmeli et

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<sup>13</sup> Houle pleaded guilty and was sentenced to 3 years probation (Schwartz & Lutfiyya, 2009).

al., 2006). A similar representation was found in the media portrayal of Sean Davison<sup>14</sup> who was produced in the Aotearoa New Zealand media as a martyr for assisting his mother to die (Revell-Dennett, 2018). Family members involved in the act of euthanasia are not however always rendered heroic in the media. In another local case, the media represented Lesley Martin<sup>15</sup> negatively. Martin was described her as a “failed nurse” for her involvement in her mother’s death, someone whose professional judgement was impaired, and her family life was portrayed as marred by conflicts and separation (Revell-Dennett, 2018, p.174).

Heroes could also be health professionals or politicians who supported euthanasia. The hero imperative was depicted in McInerney’s (2006) study where she argued Philip Nietzsche, the former Australian physician who founded the pro-euthanasia group Exit International, was hailed in the media as an *unconventional hero* who promised to save victims from the ravages of death, similar to Jesus Christ. Nietzsche himself is said to have described his involvement in heroic terms, enjoining other doctors to become *medical heroes* by participating in assisted deaths; and the media endorsed this representation of Nietzsche calling him a crusader and courageous. In the same study, a lone politician who supported legalising euthanasia was portrayed in the press as a *rebel hero*, altruistic and also described as courageous. Those that stood in opposition to legalising euthanasia were characterised as *villains*.

While the hero frame was deployed in multiple studies, only McInerney (2006) analysed the villain character. Where the terminally ill were represented in the press as victims

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<sup>14</sup> After unpublished details from his book were leaked to the police, Davison admitted assisting his mother to die, and served 5 months home detention (Revell-Dennett, 2018). Davison, a strong advocate for euthanasia, has recently been charged with a third murder in South Africa (Deguara, 2019).

<sup>15</sup> After releasing her book *To Die Like a Dog* (2002), Martin’s involvement in her mother’s death was viewed as an admission of guilt, and she was convicted and jailed for 15 months for attempted murder (“Martin Jailed”, 2004).

of their bodies and diseases they were simultaneously portrayed as needing rescuing from the villainous. McInerney noted a discourse of *fearful villainy* whereby politicians opposed to euthanasia were portrayed in the media as gutless and fearful by shying away from hard decisions. Medical doctors and psychiatrists who refused to participate in euthanasia were similarly constructed as *fearful villains* and described as weak, cowardly, frightened, and blind to the suffering of others.

**Drama and tragedy.** Another media practice is that of focussing on the dramatic and tragic aspect of death and dying (Seale, 2010). This style of reporting was evident in three of the studies commented on above in the earlier media section. In analysing the deaths that occurred during the period of the ROTI Act 1995, McInerney (2006) noted that the Australian papers pre-eminently relied on *drama and negativity* in the portrayal of death. Bodies were described in the media as “rotting, wasting, oozing, malodourous, deformed, incontinent”, (McInerney, 2007, p 393) and it was claimed that the body in decay and disarray met the media penchant for *drama and crisis*. A dramatic framing extended to the way media represented death for those denied euthanasia; stories suggested death without euthanasia would take a violent form, such as slashing your wrists , throwing yourself under a train or by gassing yourself (McInerney, 2007). In these portrayals, death by euthanasia was a way to protect loved ones from a dramatic and tragically negative death. In Hausmann’s (2004) research of British newspapers, perpetrators and recipients of assisted suicide were represented as *tragic* cases and sympathetically treated. She argued that this representation established a rationale for euthanasia, deflecting accountability away from any wrong doing. The aforementioned representations of euthanasia have demonstrated how media influence social practices, but just as important from a critical research perspective are the aspects that were not covered or downplayed, and this is where we turn to next.

## Absent Voices, Silencing and Omissions

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Discursive formations are defined as much by what lies outside of them, what and who was rendered silent, marginalised, oppressed or simply absent altogether. One way the media is implicated in this process is through agenda setting and gatekeeping by not engaging with parties on opposite sides of a debate, or providing little coverage that contests dominant social perspectives (Ott & Mack, 2010). This final subsection focuses on research that sought to analyse such practices of exclusion and marginalisation.

**The Church.** The views of the Church<sup>16</sup>, were rarely mentioned in euthanasia stories which is an interesting finding given the Church's previous interest in morality laws such as abortion and same-sex marriage. The absence of views held by the Church was explored briefly by Birenbaum-Carmeli et al. (2006) who identified that as well as silencing opposing voices journalists often positioned criticisms towards euthanasia by the Church to a couple of sentences at the end of a news article, thereby ignoring arguments put forward by the Church. The marginalisation of the Church in euthanasia discourse may be related to the increasing secularisation apparent in the countries where the studies took place (Wilkins-Laflamme, 2016), and as such, it is possible the power of the Church in addressing the euthanasia debate in the media has been reduced. Another possible explanation could relate to the liberal inclinations of the media who choose not to represent the views of anyone working to curtail neoliberal notions of freedom.

**Palliative care or hospice.** Two studies noted little coverage was given to palliative or hospice care as a suitable alternative end of life care option to euthanasia. McInerney (2007) claimed consideration of palliative care in the media was rare, and when any acknowledgment occurred about palliative care and end of life care, it was made in a dismissive manner, with

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<sup>16</sup> The Church here means the dominant Christian faith practiced in Canada, North America, Britain and Australia were the aforementioned critical studies were based.

greater emphasis in stories about how symptoms could not be controlled. Birenbaum-Carmeli et al. (2006) likewise found no serious representation of end of life alternatives such as palliative or hospice care. They argued media bias towards euthanasia was due partially to the process of omissions about alternatives to euthanasia. One tactic was to relegate opposing voices to only a couple of sentences at the end of article, much like any reference to the Church, which created the illusion of a balanced view, but actually served to enhance the support of euthanasia by disallowing any substantive engagement with arguments against euthanasia (Birenbaum-Carmeli et al., 2006).

**Views of the disabled.** The perspectives and experiences of disabled people were missing across all studies. What is more, no effort was made to present positively the experience of life with a disability in North American and Great British media stories about euthanasia, nor in the stories that followed the lives of Marielle Houle and her son (Haller & Ralph, 2001; Schwartz & Lutfiyya, 2009). It was claimed that by not presenting the possibility of living a positive or full life with an impairment, these people were written out of existence (Schwartz & Lutfiyya, 2009). Haller and Ralph (2001) argued that where a society sees no value in the lives of disabled people, there is no obligation to include alternative views. Given the historical injustices associated with disabled people and euthanasia (for example, Aktion T4), this point is particularly pertinent as modern-day understandings of euthanasia and eugenics were seen by the disability advocates in Haller and Ralph's research as fuelling an obligation to die. By not focussing any stories on why disabled people oppose euthanasia, political and social justice issues related to health care costs and lack of resources were ignored.

**Media's pro-euthanasia stance.** Comparing media and 'expert' discourses in Aotearoa New Zealand, in her doctoral dissertation Revell-Dennett (2018) found that the media portrayed a pro-euthanasia position and on the few occasions that opposing views were represented (such as that expressed by the Care Alliance), they were framed as interfering.

Expert discourses that occurred outside of the media were said to illustrate the richness of the death experience, the responsibilities that come with rights, potential changes to medical practices, slippery slope arguments, sanctity of life issues, and the challenge of judging the quality of another person's life and the implications of this on advanced euthanasia directives. This research aligned with international literature that claimed that the media legitimates euthanasia by ignoring certain anti-euthanasia aspects of the euthanasia debate in favour of pro-euthanasia arguments (Birenbaum-Carmeli, 2006; Hausmann, 2004; Haller & Ralph, 2001).

In summary, this section considered certain media and journalistic practices that inform the construction of euthanasia discourses. Across many studies, the use of storytelling characters portrayed pro-euthanasia people and entities as heroic and martyrs, and those opposed to euthanasia as villainous. Dramatic and tragic images were seen to garner saleable media content, while the final part of this section considered whose voices had been excluded and marginalised by the press and media's pro-euthanasia stance.

This concludes the first part of this thesis where the main arguments for and against euthanasia were outlined, the use of certain terminology was explored and the legal, social, economic and cultural context were discussed along with the common understanding of euthanasia as asserted in mainstream research. It concluded with how euthanasia can be known through language, text and discourse. To demonstrate the usefulness and validity of this research, the second part of this thesis outlines my theoretical and conceptual models, methodological framework and is explicit about my research design and methods. I do this so that the reader understands how I drew my conclusions, which are inevitably partial as all meaning is negotiable (Yardley, 2000; 2016).

## **Chapter 3: Theoretical and Conceptual Framework**

This chapter begins by me reflecting on the way in which my socio-cultural position as the researcher has shaped this work. Next, I discuss social constructionism, the epistemological underpinning on which this thesis draws its assumptions about ‘reality’ and knowledge. I then outline the notion of discourse, how it matters and how the term is taken up in this thesis. Foucauldian analytical influences including notions of power, subject positions, how the ‘self’ is understood, and how discourse influences our subjectivities is then detailed. Finally, this chapter ends with consideration of how media power is understood, and what media tools inform the analysis and discussion forthwith.

### **My Position as a Researcher**

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Unlike mainstream positivist psychological research that assumes value free objectivity, the research approach I have taken maintains the researcher cannot stand outside of the research they produce, and as such, they are implicated in some way (Willig, 2001). In choosing social constructionism as my epistemological orientation, I value how this work is necessarily constructed through my authorship and informed by my beliefs, values and assumptions, and of course my history and social context. Who I am as researcher has mattered to the questions I have asked and the answers I have found, and in this way, I begin this chapter by recognising my position within this study.

I am a New Zealander of European descent, non-disabled, married, female, educated, middle class, and a left-wing political supporter. These categories while presented as discrete, are not inseparable from each other. I am from a fundamentalist Christian upbringing although I consider myself more spiritual than religious these days. My Christian upbringing informs my relationships, especially with my father who believed God chooses the time of death. My

religious history made it challenging, at times, to engage with criticisms about the Church while interpreting the data, however any bias was attended to with awareness and explicitly recognising my position.

My social and historical context mattered in that I am neither chronically or terminally ill, frail or dependent, disabled or old. Moreover, with private medical insurance, I am not currently vulnerable to economic pressures. It could be argued I hold an outsider status to those whose views are more relevant to end of life conversations. This brings with it some drawbacks, for example I cannot fully comprehend how the euthanasia discourse might act on the disabled person or older adult who may be positioned as vulnerable in the media. I also risk missing themes that might be known to others who occupy different groups to me (Berger, 2015).

My interest in how euthanasia is portrayed in the media was derived from reading about Lecretia Seales in the Aotearoa New Zealand press, and finding myself emotionally distraught. Before she died, Seales made a claim to the High Court of Aotearoa New Zealand, seeking the right to end her life with the support of a doctor, on the basis that the Crimes Act was inconsistent with the Bill of Rights. Here I was crying about the death of a stranger and I wondered how it could be that a media story could invoke such a powerful response. That got me curious about how euthanasia was constructed in the media.

Many times, over the past year I have been asked if I am in favour of legalising euthanasia. And indeed, I commenced this research firmly in the pro-euthanasia camp, however, my views are no longer so assured. My support for legislation now depends on what safeguards can be put in place for people who are vulnerable, and if more is done to improve access to culturally appropriate and inclusive healthcare at all stages of the life course.

## **Social Constructionism**

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Social constructionism shares assumptions with postmodernism and poststructuralism about what we can know, and how knowledge may be acquired. Therefore, to understand social constructionism, an understanding of postmodernism and poststructuralism is necessary.

Postmodernism rejects essentialism and foundationalism, the view that things have essential pre-existing characteristics waiting to be discovered; and the idea that what we can know is traceable back to an immutable truth, a base to which all truths can stand (Sarup, 1993). Poststructuralism is viewed as a form of postmodernism that is also concerned with relationships of power. Furthermore, poststructuralism is defined by its denunciation of the structuralist premise that the world is understood by uncovering structures. Poststructuralism shares with postmodernism a rejection of the notion of fixed meaning, and holds that meaning is created through language use in social relationships (Blackburn, 2016).

Although social constructionism arose from diverse fields including philosophy, anthropology, sociology and psychology, some critical assumptions are shared (Cooper & Thorogood, 2013). Firstly, social constructionism maintains that our knowledge and understanding of the world is contingent on our historical and cultural location within it, and dependent upon prevailing social, economic and political arrangements in that specific culture at that specific time. Secondly, social constructionism argues that language shapes everyday 'reality' and far from describing the world, constructs the world. Furthermore, language is not neutral, and actively shapes what can be known (Tuffin, 2005). Thus, discourse and discursive practices have a special place in social constructionist research. Thirdly, the 'self' as an entity is constructed through discourse. Fourthly, social constructionism assumes that meaning is not inherent in phenomena itself, but transmitted via language and shared understandings. Consequently, meaning is never fixed and always contestable. And finally, social constructionism contends that what we can know about the world cannot be objectively

observed, instead, reality is constructed through relational processes of social groups, language and discourse (Burr, 2015). In this sense, the same phenomenon can be read in multiple ways as human experience is mediated historically, culturally and via language use (Gergen, 2011).

While social constructionism offers new ways to understand the phenomenon of euthanasia, to say euthanasia has no reality beyond its social construction, raises an ontological question about the experience of pain and death as embodied beings. Whereas epistemology grapples with questions such as what can be known, ontology wrestles with concepts related to being, existence and reality and in this research, following Parker (1998), I take up a 'critical realistic' perspective which gives ontological status to some aspects of the material world and accept there is a world beyond the text. I do not deny that pain is 'real' for people, also accepting that pain is a social construct. Just as we live in our bodies, we die in our bodies which are impacted by social, cultural and material factors.

**Forms of social constructionism.** While the critical assumptions of social constructionism as noted above are commonly accepted, research has typically aligned itself with two main forms of social constructionism. These have been characterised with various terms, such as 'light and dark', or 'strong and weak', however to reduce any unintended negative connotations I use the terms 'micro and macro' as posited by Burr (2015). The micro form, usually seen in discursive psychology, focuses on intimate dialogue and the linguistic devices people use to achieve their goals and perform psychological phenomena, whereas, the macro form situates power as central and draws heavily from the work of the French thinker and philosopher, Michel Foucault who was interested in the role language played in social power relations, the material and social structures that form the context for these, and how discourses produce subjectivity (Burr, 2015). While not denying the constructive force of language, macro social constructionists see discourse and language as closely connected with social relations, institutionalised practices, and material or social structures (Burr, 2015). This

thesis adopts the macro form of social constructionism to explore the social power relations that surround the phenomena of euthanasia and the various meanings and versions of reality constructed through the use of language and discourse in the Aotearoa New Zealand media. Furthermore, it considers how this might impact what we can feel, think and do in relation to the discourses available. While I have previously explored the media's role in the development of discourses, as the term discourse is understood in multiple ways, it requires me to position how I understand and take up this notion in my analysis.

### **Discourse**

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My understanding of discourse is drawn from the meaning developed by Foucault. This work views discourse as a pattern of text, or a series of events or statements, that in any specific socio-historical moment forms the objects that can be written, spoken or thought about. Foucauldian discourse is particularly concerned with what enables and constrains social objects or practices at any given point in time (McHoul & Grace, 1993) and challenges us to think critically and unpack the assumptions of what appears 'natural', 'taken-for-granted', 'common sense', and to consider how prevailing discourses support the self-interest of dominant groups (Cooper & Thorogood, 2013). Discourses can be both an instrument and an effect of power, they transmit, produce, undermine and expose power (Foucault, 1978,1990). A range of Foucauldian analytical concepts have been drawn upon in this thesis to unpack and represent how discourses of euthanasia are constructed, and what they make possible for people to feel, think, and do in relation to the practice of euthanasia, which are outlined below.

### **Foucauldian Analytical Framework**

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Foucault's thinking provides a framework for the analysis of power and its effect on the body. Foucault rejected the idea of a central power emanating from a Sovereign, State, 'individual'

or class instead arguing power has network like characteristics, that is, power is everywhere and circulates within social relationships that operate both bottom up and top down (Dreyfuss & Rabinow, 1982). Unlike traditional notions that viewed power as repressive, limiting and obstructive, Foucault recognised power can be productive, and when exercised it produces ‘reality’, creates new objects of knowledge, regimes of ‘truth’ and as explored in the next section, power can act as a form social discipline. What we come to believe as truth is produced out of power struggles between different fields, disciplines and institutions. Truth and knowledge are therefore inextricably tied up with power (Sarup, 1993).

**Disciplinary power and biopower.** According to Foucault, two forms of power emerged in the eighteenth and nineteenth century that worked on the body (Foucault, 1975-76 (2003)). Disciplinary power arose to fulfil a requirement for a healthy, strong and well-ordered workforce; bodies were required to be ‘docile’ and willing to accept control and instruction and most importantly, police their own behaviour. This policing was coined ‘self-surveillance’, and considered to be the most economical form of power as it did not require the State or Sovereign to monitor and oversee its completion (Boyne 1990). Biopower arose as a response to the State’s requirement to control its population and centered on procedures that manipulated biological features, such as birth and mortality rates. Its emergence saw the introduction of new apparatus and mechanisms, for example, statistical estimates and forecasting, alongside new institutions such as health and life insurance (Foucault, 1975-76 (2003)). Disciplinary power and biopower are useful concepts to analyse power relations. In this thesis they enable an exploration of the kind of bodies needed for society to function, how biological factors such as mortality rates are currently controlled, and what assessment and surveillance practices are used in disciplinary practices of a ‘self’. However, it is also paramount to consider the specificity of the socio-political context behind relations of power, and for this, Foucault’s concept of governmentality, as a tool for neoliberal analysis, is useful.

**Governmentality and technologies of the self.** According to Lemke (2001), Foucault viewed governmentality as an extension of biopower focussed not only on biological features, but on all aspects of life, such as, guiding the ‘family’ or directing the ‘religious soul’ and was comprised of the following features. Firstly, Foucault referred to governmentality as the *conduct of conduct*, that is, how we govern ourselves and others within a liberal ideology that asserts the sovereignty of the ‘free individual’, yet requires behaviour to be regulated and modified. Secondly, he argued liberal ideology (and its modern form, neoliberalism) required the transference of risk from the State to the ‘responsible and economically rational subject’ and that Western values such as, individualism, choice and autonomy ensured the consequences and responsibility for decisions would reside with the ‘individual’ alone. Finally, Foucault argued that the notions of liberty and freedom are artificially created to provide the illusion of choice and ‘individual’ control. Governmentality is therefore a useful analytical tool to consider for example, the intersections between neoliberal ideology, various institutions such as Medicine or the Church, and how people govern themselves and their family regarding the practice of euthanasia. Another notion of power related to governmentality was referred to by Foucault as *technologies of the self*.

Technologies of the self are various transformative techniques and risk management strategies that subjects use to seek a certain quality of life or happiness with regard to their bodies, minds, souls and conduct as a response to what is available in the local culture, social groups and society (Yates & Hiles, 2010). Relevant technologies to this thesis include those of Responsibilisation, Healthism, and Normalisation. Responsibilisation is fettered with neoliberal techniques of transferring risk from the State, providers or producers to the subject. Applying a neoliberal lens of Responsibilisation to health/illness suggests health is the outcome of choices made by responsible citizens who hold the knowledge, skill and motivation to manage their own healthcare (Anderson et al., 2016). Healthism is a term used to denote

various regimes of health through which subjects express Western values of capitalism and individualism such as self-discipline, self-control, and autonomy (Cooper & Thorogood, 2013). These values are described as the “qualifications considered important to being a ‘normal’, ‘healthy’ human being” (Petersen and Lupton 2000, p. 18), and take on a moral form when used to judge the behaviour of others (Crawford, 1980). Normalisation persuades us to internalise the prevailing norms and values of the society we live in, acting on both dominant and marginalised groups. Although norms themselves appear natural, in order to achieve ‘normality’, people are required to work on their behaviour to fit the dominant social model (Danaher, Shirato & Webb, 2000). These aforementioned technologies act alone, and in combination to produce subjects or groups who monitor their conduct in line with norms set by experts (Anderson et al., 2016). This work considers the implication of Responsibilisation, Healthism and Normalisation in the construction of euthanasia in the Aotearoa New Zealand media.

**Subject positions, the ‘self’ and subjectivity.** From a Foucauldian perspective, the effects of power are brought into existence within discourses that facilitate and limit, enable and constrain, what can be said, by whom, where and when, and which offer us ‘subject positions’ with implications for human experience and subjectivity (Parker, 1992). For example, within a *biomedical* discourse being positioned, or taking up the position of a ‘patient’ means that the body becomes an object of legitimate interest to doctors and nurses and may be exposed, touched, and invaded in the process of treatment which forms the practice of medicine and its institutions (Willig 2000 p. 107). People can take up multiple subject positions, which may be both discontinuous and contradictory. For instance, staying with *biomedical* discourse, those who are terminally ill may occupy the subject position of *the dying*, locating them as the passive recipient of expert care, and they may also take up the position of *household provider*, which may locate them as a subject responsible for the wellbeing of others. These competing

and potentially contradictory positions do not need to be resolved, they are expected (Rutherford, Sheese, & Ruck, 2015).

Identifying the subject positions within euthanasia discourse provides an understanding of a moral location within a social interaction and defines the historical limits of what can be, written, said or practiced at a certain point in time (Arribas-Ayllon & Walkerdine, 2017). By taking up various positions, subjects accept a system of rights and duties that carries expectations of how to think and behave thus providing the content of their subjectivity in relation to a particular subject position. Hence, our very thoughts and feelings are formed through the social processes of power the subject positions offer to us via discourse. Subject position formation is said to take place not only in the media, but across multiple sites (Türken, Nafstad, Blakar, & Roen, 2015), however, in this thesis, the media is the primary place in which analysis is conducted.

This notion of subject disrupts the commonly understood psychological view that assumes there is an 'essence' inside of people that makes them who they are, a self who is unified, stable and self-contained (Burr, 2015). This research understands the 'self' as a subject that is inscribed by discourse, malleable, and culturally and historically situated. By adopting this approach, this is not to say that there is no possibility for self-directed action, for while Foucault argued no pure autonomy exists, he also claimed there is always the possibility of resistance as counter-discourses can, and do eventually emerge, thus change and transformation are always possible (Yates & Hiles, 2010). Here I follow Burr's (2015) thinking that a person is able to take up or resist positions within discourse while acknowledging such undertakings are limited by the discourses themselves, and material constraints. In summary, the previous sections reviewed the epistemological and ontological orientation underpinning this thesis, and discussed the Foucauldian conceptual thinking which guides the later analysis

and discussion of social power relations. The next part of this chapter turns to consider how media is understood.

## **The Media**

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Media is an institution of power in its own right. There are two main ways in which media power is understood in this thesis. Firstly, power is accumulated behind the text as media is acted upon by dominant ideologies and subject to persuasion by institutions and interest groups who frame issues in certain ways that meet news values (Giles 2003). For example, it could be argued David Seymour's #MyLifeMyChoice campaign made its way into mainstream newspapers in part by creating video content, a popular contemporary marketing tactic that appeals to news values of entertainment, and is also an example of political power and ACT party ideology. Secondly, media has its own norms and values and power manifests through the pressures to create 'newsworthy' stories and various institutional and journalistic routines. With the range of ways that media exercise power, particular journalistic practices, as discussed earlier, are now unpacked further below to present how they are complicit in the construction of euthanasia. At times counter discourses and resistance may emerge as the media is acted on by external and internal power. For example, while the media is said to support a pro euthanasia stance, some 'rogue' journalists may pen opinion pieces in opposition to euthanasia.

**Words, metaphors and storytelling.** As the previous chapter represented, imagery and words employed in the media construct objects, concepts and people. These images and words engaged by the media produce particular ways of viewing things (Lyons 2000). For instance, regardless of whether an argument is for or against euthanasia, the use of titles such as Doctor and Professor reinforce an expert status adding weight to the credibility of any opinion. Metaphoric language, as used by the media, also has a powerful influence on how we perceive and understand health, illness and disease (see Lakoff & Johnson 1980, Johnson & Lakoff

2002, and Quinn 1991). Storytelling is another analytical frame in which media practices are reviewed. Victims, villains, and heroes are the most commonly used story characters as it is assumed they evoke emotions in media audiences (Jasper et al., 2018). This strategy is important to media because emotional engagement is thought to provide a more entertaining experience, and media audiences seek entertainment (Seale, 2003). In this work I consider the way in which the characters of victims, villains and heroes work, not only in relationship to the people that feature in the media stories, but also with consideration of institutions like the Church to support my conclusions about what feelings may be aroused within the subject positions offered.

**Framing and personalisation.** Media is said to prefer dramatic, episodic frames and personalisation of cases that treat news as independent, discrete events over thematic framing which attends to broader socio-political-cultural aspects (Iyengar, 1991, cited in Birenbaum-Carmeli, Benjeree, & Taylor, 2006). Episodic frames are thought to garner greater readership, and to privilege the ‘individual’ case over broader arguments against euthanasia (Birenbaum-Carmeli et al., 2006; McInerney, 2006). Personalisation through the use of personal and proper pronouns is said to promote relatedness between the character of a news story and its audience and influence ‘newsworthiness’ (Bednarek & Caple, 2014), thus making news a saleable commodity. How the media covers euthanasia stories and debates, the forms of authority relied on, the moral judgements inferred, the frames deployed and personalisation all have a role in influencing social policy development, social practices and the subject positions available for people to take up.

In summary, this chapter outlined my position as a researcher and how it mattered to this work. An outline of the epistemological, theoretical, and conceptual approaches that have informed this work, and certain Foucauldian terminology, has also been considered. I have reflected on the concept of subject positions and their relationship with the ‘self’ and

subjectivity and how this influences the way people take up or resist discourses. This chapter closed with deliberation of how the media is considered herein. The next chapter outlines the research design.

## Chapter 4: Research Design

Little research exists within Aotearoa New Zealand that considers how media constructs our contemporary understandings of euthanasia and what this offers in terms of what it is possible to feel, think and do with regard to end of life decisions. To address this gap, this research offers an understanding of the construction of euthanasia in the local media and seeks to trouble the dominant discourses that privilege versions of social reality which legitimate existing power relations and social structures. Of particular interest was how the production of euthanasia intersected with neoliberalism, ageing and disability. I briefly outline the ethical considerations undertaken. I then detail the data collection steps followed and the analytical framework utilised to analyse the media articles and reader comments.

### **Ethics**

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Research using online data is an evolving space, therefore to better understand the ethical concerns for this project academic articles were reviewed, discussions with student-peers were held, and the Chair of the Massey University Ethics Committee was consulted. A range of documents were also reviewed including Massey University's code of ethics documents, Health Research Council Guidelines, the Privacy Act, the Harmful Digital Communications Act, statements from the Office of the Privacy Commissioner, Privacy by Design: 7 Foundational Principles, (2011), and the Association of Internet Researchers Ethical decision-making and Internet Research 2.0 (2012) guidelines.

It was ascertained that human subject research norms did not apply as the data in this study was from journalism articles, opinion pieces and commentary posted by readers who engaged with online news sites which were treated as authored text. As such, informed consent

was not required. Additionally, the website terms and conditions from which the reader comments were taken, outlined that comments could be used for research purposes.

Further safeguards were put in place to ensure appropriate use of the material. For instance, news stories were credited in line with standard referencing protocol. Reader responses were anonymised and any identifying information omitted. For ease of reading, readers were assigned fictitious names based on an Internet search of popular names in Aotearoa New Zealand, and no inference was made about gender. Direct quotes were not used to avoid creating a digital trail that identified a reader through the linking of fragments of online data, and the process of entering reader quotes into the Google search engine was undertaken to ensure readers were not identifiable. The maximum level of anonymity for people who shared sensitive health information was given, again no direct quotes were used, and if necessary data was presented in aggregate form. If someone revealed their age as under 16 years old, comments made by them were removed from the research.

To address cultural appropriateness related to my research interpretation, I drew on the writing of Ngata (2005) who wrote about Māori perspectives on death, dying and grief, and I looked for examples of Māori ways of being such as collective culture and kinship, and holistic perspectives on dying practices in the media. I also looked for examples of tikanga Māori (traditional customs), and references to contemporary socio-environmental changes that might influence the euthanasia debate. According to Nairn et al. (2011) mass media can be an “obstacle to cultural competence” (p. 168) through its presentation of the dominant culture as ‘naturalised’ and the marginalisation of indigenous voices. As such, I looked outside of mainstream media for Māori voices to inform my interpretation. I also shared my interpretation with my supervisor who has knowledge of, and a strong connection to Te Ao Māori (the Māori world) and a Māori scholar Natasha Tassell-Matamua, who researches and teaches indigenous psychology and mātauranga Māori (knowledge), including ethics. Their guidance was

important in shaping how I engaged with Te Ao Māori, and I reflected their feedback in my final documentation. Ethics approval was granted by the Massey University Ethics Committee, Notification Number: 4000019549.

### **Data Collection**

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A three-month window from 1<sup>st</sup> February 2018 until 30<sup>th</sup> April 2018 was chosen to collect data as this period coincided with two *critical discourse events* - the closing of the EOLC Bill submissions to the Justice Select Committee, and the trial of Susan Austen for the assisted suicide of Annemarie Treadwell in Aotearoa New Zealand. According to Carvalho (2008) critical discourse moments, or the periods of time when specific events occur, provide greater opportunities to challenge discursive positions that are taken for granted. It was also important to explore opportunities for counter discourses and resistance to the dominant representations.

After setting the key word search criteria of Euthanasia OR voluntary euthanasia OR physician-assisted suicide OR assisted suicide, OR assisted dying, the initial search returned 75 articles, 15 letters to the editor and hundreds of online reader comments. Themes covering moral, ethical, legal, religious and medical issues were noted across all data sources. Much of this data was repetitive and did not add value, so a decision was made to reduce the data set to a manageable amount that could yield meaningful analysis. As this research was interested in unpacking dominant discourses, the most popular national publications were chosen as a way to reduce the data set. Results were therefore limited to the online newspapers, including The New Zealand Herald and two of its regional papers, namely, The Dominion Post, The Press, and Stuff. This data reduction process left 45 articles for analysis, with over 100 uniquely identified readers and more than 500 responses. Only the publication Stuff allowed online comments and as such, the subject position quotes are drawn from this content only. I do not consider this a limitation as the same themes that informed the discourses were present across

both Stuff and The New Zealand Herald. The total corpus was 66150 words. Of the media articles produced in a three-month period, 6 were made open for comment to the general public for comment. These are described in Appendix B.

## **Data Analysis**

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Foucauldian Discourse Analysis (FDA) was used to unpack the data. FDA is an analytical process that seeks to explicate the structures and social power relations around a text that make it possible, while also considering what lies outside of the discursive formations, and to surface the oppressed, marginalised and subordinated alternative understandings. As Foucault did not stipulate an analytical process, this study adopted Carla Willig's (2008) six stage approach to FDA. This framework enabled a comprehensive analysis, that was flexible enough to adapt to this project.

**Adapted Foucauldian Discourse Analysis process.** The first stage involved me becoming familiar with the text. This was done by reading and highlighting passages in both the media and reader data sets for further reflection. At this point, anything vaguely relevant was included. The data was read numerous times with attention paid to the way in which the particular objects of inquiry (e.g. dying, euthanasia, disability, ageing) were constructed. The data was then analysed for variations and similarities between texts and between the data sets, looking at what issues were conflated, and what the various discourses enabled and constrained. Consideration was made of how each discourse might be located in wider discourses, and how this might influence upon the interpretation of the text. The data sets were re-read with the lenses of disability, ageing, and neoliberal forms of governmentality along with the portrayal of embodied experiences of death and dying. In the third stage, the "action orientation" of the objects was examined to gain clarity as to what the various constructions

were capable of achieving. This entailed exploring what was gained, lost and maintained by constructing the object in a certain way. Attention was then turned to stages four to six.

The fourth stage addressed how power functions to achieve certain subject positions. Here I was interested in how subjects were positioned in relation to each other, and how power circulates through these positionings. For this stage, focus was on the subject positions identified in the media text and how they were taken up by readers. I looked at opportunities for action that were opened up, or closed down by the subject positions. I also looked at what could be said and done within the various subject positions. The sixth and final stage involved hypothetical contemplation of what could be felt, thought and experienced from within the subject positions. In addition to the FDA process, I paid attention to which voices were silenced, marginalised or oppressed and as a secondary consideration, if the media reported a bias in favour of euthanasia. Finally, I reflected on my role as the author of this text. This process enabled me to critically reflect on the reading I present on media construction of euthanasia, what this research contributes to the field of euthanasia, research constraints, future implications and my role as a researcher.

### **Media Analysis**

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To draw out knowledge about how media power operated in and through discourse, I also considered the rhetorical devices discussed earlier, such as metaphor, storytelling, drama and tragedy. I was interested in whether rhetorical devices positively or negatively skewed the representations of euthanasia, and what kind of characters were portrayed in stories about euthanasia. As mentioned in the theory section, I considered storytelling characters to gauge the emotional valence and to consider how this might affect what readers felt.

In summary, this chapter outlined the ethical considerations undertaken and how the data was collected and analysed. In ending this second part of the thesis, I will restate my

primary research question, and the other key questions that guided my analysis to enable and engage a reading of the analysis chapters based on these questions. They were:

- 1) How is euthanasia constructed in the Aotearoa New Zealand media, and how do readers take up this construction in terms of what can be thought, felt and done?
  - a) What subject positions are offered by and how does power circulate through these positions?
  - b) How is the disabled, ageing, or dying body perceived, negotiated, reinforced and/or challenged?
  - c) How do neoliberal practices intersect with the euthanasia discourse produced in the media?

## Chapter 5: The Autonomous Right to Choose Discourse

This chapter focuses on the construction of the prevailing media discourse, the *autonomous right to choose* which involved the discrete but interrelated belief that an independent ‘individual’ could make legitimate and rational end of life decisions. Due to these notions, key aspects such as ‘autonomy’, ‘rights’, ‘choice’, the Church, Medicine and the State<sup>17</sup>, as well as the privileged neoliberal Western subject are unpacked and related back to literature. The chapter also discusses the counter discourse, *perilous*. Finally, the subject positions of *my choice and mine alone*, and *the defender of rights* that arose from the *autonomous right to choose* discourse are unpacked. These subject positions are located in the readers’ comments to the media articles. Overall, the analysis looks at what this discourse enabled and constrained, and what was gained, lost, and maintained by producing euthanasia in this way.

As outlined earlier, during the period analysed two stories dominated the media, the proposed End of the Life Choice Bill submission (EOLC Bill) led by ACT party leader David Seymour, and the trial of Susan Austen for aiding the suicide of Annemarie Treadwell. At the time of the data collection, the EOLC Bill was in its final phase of calling for public submissions to the Justice Select Committee. While in late February 2018, Austen was found guilty of importing the euthanasia drug pentobarbitone, and found not guilty of assisting in the suicide of Treadwell. These stories are frequently referred to in the media analysis below, along with references from Treadwell’s diary which was referred to extensively in the media.

### The Autonomous Right to Choose Discourse

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**Autonomy.** In the media, euthanasia was primarily constructed as an autonomous decision that did not require consultation. This was exemplified in the campaign slogan of

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<sup>17</sup> The State refers here to the collective Members of Parliament and governing bodies.

Seymour's EOLC Bill "#MyLifeMyChoice". This repeated message produced euthanasia as an end of life decision that is made "alone". The quotes below are from two of the five people who fronted the #MyLifeMyChoice campaign, with each representing the importance of autonomy:

Carroll said she alone should choose when her life would end (Nichol, 2018).

"[The EOLC Bill] allows for a terminally ill New Zealander to be able to access assisted dying if they choose to. You are still a human being with choices, you are still a human being who is able to make decisions for themselves" (Walters, 2018a).

The first statement by Carroll that "she alone" should decide when to die can be read in a number of ways. One interpretation is that dying should not be influenced by religion, medicine ideology or laws that make euthanasia illegal. It could also mean that taking in the perspectives of others or consulting with friends and family is not necessary. The second quote from Matt Vickers, the husband of Lecretia Seales, similarly represents the importance of autonomy with the dying making decisions for "themselves".

Overall, the exercising of autonomy is presented as being within the 'individual' rather than within relationships, and decisions about euthanasia are acted on voluntarily without the influence of others. Portraying euthanasia as self-determined had the effect of making euthanasia appear free from coercion. This representation is similar to research by Hausmann (2004) who alleged that in the British press euthanasia was understood as voluntary, a key pro-euthanasia argument that assumes the decision for euthanasia is made free from undue influence and coercion.

Autonomy, as depicted by the media, engaged neoliberal values of independence and individualism, and reproduced a particularly Western subject, sharing similarities with other critical research (Birenbaum-Carmeli et al., 2006; and Clarke 2004). Ignored within this discourse were experiences of community or collective cultures, such as Māori, where relationships with the extended family and whānau are valued over personal autonomy (Frey et al., 2014). Emotional or relational ways of knowing autonomy (Donchin, 2000; Van Brussel, 2014) in the media were also absent. Viewing euthanasia and decisions about dying through emotional and social processes acknowledges interdependence, and contests sole responsibility for meeting one's end of life needs. Exercising 'individual' autonomy was however portrayed as more important than the involvement of others, or the effect of taking up euthanasia on those closely involved in the process, and society more generally. Similarly, the concept of supported autonomy, a term that acknowledges that, at times, disabled people require assistance in exercising self-determining actions, was overlooked (Bouwmeester, Harpe, & Polhuis, 2010). The exercising of autonomy and decisional capacity for euthanasia are highly complex issues that matter to disabled people (Tuffrey-wijne, Curfs, Finlay, & Hollins, 2018), yet in the period analysed, discussion around these issues was absent.

Euthanising people who suffer from mental illness also does not fit the traditional notion of autonomy, as any conscious rational control over death is questionable (Vulcănescu, 2018). The way euthanasia was constructed in the media worked to exclude the mentally ill by drawing on mainstream understandings of mental illness and rationality. This exclusion is highlighted below in Seymour's comments:

“A person with any kind of serious mental illness, by definition, has a distorted view of what ending their life means. If your argument is I'm depressed and I want assisted dying, the rules actually exclude you” (Manch & Nyika, 2018)

Seymour contended that “any kind of serious mental illness” results in a “distorted view” of what ending life means. These claims support the common-sense understanding that people with mental illness and/or depression cannot weigh up the pros and cons of ending life. Furthermore, it suggests a binary rational/irrational and sane/insane categorisation that aligns with a pathologised notion of health, whereby illnesses reside within a person, and ignores the social aspects of health and intrapersonal relationships. These representations are supported in mainstream research, where ‘serious mental illness’ is generally conceived as preventing rationality and the fostering of a ‘self’ that is autonomous (Hewitt, 2013), and the desire for euthanasia has been said to be lowered if depression is treatable (William Breitbart et al., 2010). The next subsection looks at another aspect of the *autonomous right to choose* discourse, rights.

**Rights.** The *autonomous right to choose* discourse also drew upon the notion of euthanasia as a human right, a common pro-euthanasia argument that claims euthanasia as both a moral and legal right:

... ACT leader David Seymour, described end of life choice as New Zealand's last great human rights hurdle. “The one area where we don’t have full autonomy over our bodies and our lives is when we die” (Walters, 2018a).

In the quote above Seymour invokes the idea of euthanasia as a progressive ideal as he denotes end of life choice as the “last great human rights hurdle”. Whether or not euthanasia is the “last” is debatable, as there are many issues related to the body and health that could be construed as “human rights hurdles”, such as decriminalising abortion, adoption law reform, drug law reform, and other social issues like child poverty. In the media however, these considerations were left unexamined. In the same article, Seymour goes on to claim euthanasia

is an inherited right and freedom within a “Western anglosphere nation” (Walters, 2018a). “Western anglosphere” refers to a common culture amongst English speaking people that reveres “individualism, rule of law, elevation of freedom, [and excludes] people who define themselves primarily as members of collective entities, be they families, religions, racial or ethnic groups, political movements, or corporations” (Bennett, 2002, p. 114). This phrase “Western anglosphere” reinforces the idea that euthanasia is a particularly individualistic Western practice and likely has appeal to European people living in Aotearoa New Zealand.

In the extract below, euthanasia is seen by Treadwell’s son as “her right”. By making it clear that while he did not believe in euthanasia himself he supported his mother’s decision to die by euthanasia as a “right”. This text represents euthanasia in a similar way to Clarke’s (2005) analysis of Canadian magazines that suggested a person exercising their right to choose death was a matter of personal preference:

She [Treadwell] had talked about killing herself for many years. He believed that was her right but he did not believe in it himself (“Woman Accused”, 2018).

Another way to view rights was depicted through an opinion piece written by Member of Parliament Louisa Wall that drew on the work of the philosopher and pro-euthanasia activist, Margaret Battin. Battin was referred to as a “Professor” affording her an expert status, a rhetorical tactic assumed to persuade people to view opinion favourably. The opinion piece involved a discussion by Battin about the 9/11 terrorist attack “jumpers” who leapt to their deaths from the Twin Towers building as it was collapsing:

Like the 9/11 jumpers, people who choose to exercise their autonomy in expressing their rights as they face foreseeable death should not be seen as doing something wrong

or sinful (Wall, 2018).

Battin contended that the actions of the “jumpers” should not be compared to suicide, due to the negative connotations associated with suicide, but rather that the jumpers were “expressing their rights” to choose death. Thus, death by euthanasia is given moral permissibility distancing it from a “sinful” death by suicide, and by asserting it as “right”.

While the three quotes above differ in their interpretation of euthanasia as a right, they all share a common understanding that what we do with our bodies in death is a human right. Rights discourse shares assumptions seen in mainstream research; universalism, humanism, and the rational ‘individual’ and according to Douzinas (2013), for rights to function, they need to be applied equally to all people, relying on idealised and abstract norms that reflect the dominant culture. It is possible then that by constructing euthanasia as a human right, the cultural and social situatedness of non-dominant cultures is ignored. Furthermore, the person who both symbolises and actualises their right is typically already privileged, “the empirical man who actually enjoys the ‘rights of man’ is a man all too man: a well-off, heterosexual, white, urban male who condenses in his person the abstract dignity of humanity and the real prerogatives of belonging to the community of the powerful” (Douzinas, 2013, p. 36). When considered in this way, it is possible to view legalising euthanasia as serving the already privileged groups in society (white, male and educated), taking attention away from other societal health issues, such as the serious inequalities in health that persist between different genders, generations, ethnic, and socioeconomic groups. Having rights does not translate to equal access to culturally appropriate healthcare. Rights discourse can also be read as acting on the privileged groups who are persuaded to enact euthanasia by appeals to have “full autonomy” over decisions about their body.

**Choice.** Choosing how and when to leave the world was understood as necessary to maintain “dignity and self-respect” with euthanasia presented as the solution to enable this. The quote below is also taken from Louisa Wall’s opinion piece:

People who have a terminal illness and we can't help anymore and who want to choose how, when and where they die should be supported to end their lives in dignity and self-respect (Wall, 2018).

‘Freedom of choice’ is an important neoliberal notion in the management of health decisions for the ‘individual’, and for a choice discourse to work, there needs to be at least two end of life options available for people who are contemplating death. By portraying euthanasia as a dignified and self-respecting death, a binary choice is implied, that death without euthanasia is ‘undignified’ that may result in a person losing self-respect. That this quote refers to people “who want to choose” implies there is no coercion.

In the quote below we return to the story of Carroll, one of the #MyLifeMyChoice campaigners who argued euthanasia should be a choice that enables death to take place while you can still “speak and recognise loved ones” and within their presence:

Dying after becoming so sick you could not speak or recognise loved ones was not dying with dignity, Carroll said... What she feared most was dying alone - if she could choose, she'd have a party to celebrate her death, surrounded by her partner of 40 years, their children and grandchildren (Nichol, 2018).

That Carroll “could chose ... a party to celebrate her death” has echoes of a *revivalist* discourse put forward by Seale (1998) that depicted dying in ways that enable people to manage

their self-identity, and participate in strategies designed to engender hopeful and positive feelings of the dying experience. A similar representation was found in the McInerney's (2007) Australian media analysis. That Carroll "feared dying alone" could be read as resistance to the Western sequestering of death, where death likely occurs as a private event in hospitalised settings (Lyons & Chamberlain, 2006).

That euthanasia should be a legal choice is conveyed by the text below which is extracted from Treadwell's diary:

At the [retirement] home she [Treadwell] found small rooms with a unit for bits and pieces to remind residents of who they were. "One could say they are being 'warehoused' because our present legislation will not allow them to make their own choice when they still have the capacity to do so" ("In Her Own Words, 2018").

The text above evokes an image of people confined within an archaic legal system unable to exercise choice about when, how and where to die. Furthermore, the use of the word "warehoused" suggests that people's choices are constrained by spatial confinement which has the potential to take away a person's freedom of choice. A change to the legislation that would allow people to make "their own choice when they still have the capacity to do so" places responsibility for the right choice with the 'competent individual'.

That euthanasia was the preferred choice of the majority of people was inferred by references to opinion polls:

Seymour leads us once more back to the United States, where a 2017 Gallup poll put support for euthanasia at 73 per cent (Mitchell, 2018).

Meanwhile, a 2015 Curia Market Research poll of 2800 people found 38 per cent of people strongly supported euthanasia, and 28 per cent somewhat support it. A total of 20 per cent were opposed (Walters, 2018a).

Readers were informed that “support for euthanasia [is] at 73 percent”. Drawing on this opinion poll however ignores the contextual and cultural differences between the United States where the poll was conducted and Aotearoa New Zealand and other issues that might influence end of life decisions, such as, access to universal and culturally appropriate healthcare. Furthermore, the underlying questions that informed the survey are unknown as they are not shared with the reader. It is possible that 73 per cent supported euthanasia for terminal patients, but not those without a terminal prognosis. The second quote similarly referred to poll results which show majority support for euthanasia. While this poll was undertaken in Aotearoa New Zealand, making it more contextually relevant, its timing occurred in a critical discourse period where stories of Lecretia Seales featured heavily in the media - perhaps influencing pollster views favourably toward legalising euthanasia. In the data collection period for this thesis, no references were made to polls that contested the common understanding of majority support for euthanasia, yet such a poll exists (Young et al., 2018). Thus, opinion polls are reported in the media as decontextualised ‘social facts’ (Rose & Osbourne, 1999) that do not address the complexities inherent in the euthanasia debate.

While the aforementioned analysis and discussion of the *autonomous right to choose* discourse has unpacked autonomy, rights and choice, the next subsection looks at the discourse in relation to three institutions of power that also influence its construction.

**Church, Medicine and the State.** In mainstream literature, religious and medical institutions have been touted as the strongest opposers to the legalisation of euthanasia. Both overseas and locally, religiosity and preservation towards life were said to be the main factors

that influenced opposition to euthanasia (Emanuel et al., 2016; Löfmark et al., 2008; Oliver, Wilson & Malpas 2017; Pedersen & Tariman, 2018; Seale, 2009). This everyday understanding of opposition to euthanasia by the Church and health professionals was carried through into the Aotearoa New Zealand media. As an institution, the Church was positioned as spreading misinformation, fearmongering and attempting to control its followers. Analysis of the Church here refers to the Catholic church as this was the only religious denomination featured in the media during the period analysed. In this way, religious pluralism and different ways of knowing death and dying were ignored. The media sidelined the concerns of the Church who claimed the definition of “irremediable medical condition” in the EOLC Bill was too vague and could include arthritis, asthma and gluten intolerance. Rather than attending to clarifying the terminology of the Bill, the article provided an opportunity for strong resistance to the Church’s influence:

Dale Lethbridge, on the committee of End of Life Choice Society Waikato, said the submission form material is disinformation. She said the idea that euthanasia could be accessed by someone with gluten intolerance, arthritis, or depression is ridiculous.

“If you were used to believing the messages of your church, you would be very frightened” (Manch & Nyika, 2018).

The comment about “frightening” parishioners into making submissions constructs the Church as an institution that exerts control over its people through fear. To invoke fear portrays the Church as villainous. By not attending to the concerns raised by the Church about the terminology used in the EOLC Bill, the views of the Church were side-lined. Previous research similarly found that views of the Church were marginalised by the press (Birenbaum-Carmeli, et al., 2006) whereby comments by anti-euthanasia Church advocates were relegated to the end

of articles. In the Aotearoa New Zealand media, the media did not engage in religious based substantive arguments against euthanasia and afforded little space to religious voices, when compared to groups supporting euthanasia.

In the next excerpt, the moral authority of the Church is challenged by the suggestion that if a person knows they are going to die, then choosing death by euthanasia cannot be classified as a “sin”:

Choosing the way you go is no sin. When death is certain, how life ends should be up to individual (Wall, 2018).

Positioning euthanasia in this way again draws on an individualistic view of morality, and it also works to reduce the power of the Church in determining moral boundaries about what is deemed “sinful”, challenging the notion that the time of death is predestined by God. Medical authority was also challenged:

Doctors and religious groups have been some of the strongest opposers of the bill.

An estimated two-thirds of doctors and one-third of nurses were opposed to the bill. Seymour said. “The bill gave the opportunity to enshrine quality of life for people until their last breath. We can allow people to have the opportunity to die with complete dignity” (Walters, 2018a).

In the extract above, that “two-thirds’ of doctors and “one-third” of nurses oppose the Bill comes across as an indisputable fact. The statement also draws on mainstream research that has found more doctors oppose euthanasia than nurses (Kouwenhoven et al., 2013). Potentially acting as a form of social control, such representations could coerce health

professionals to align with these dominant understandings. It could also be read that medical professionals that oppose euthanasia negatively influence patient “quality of life” and dying with “dignity”.

Supporting the prevailing discourse of *autonomous right to choose* was the assumption that Medicine was out of touch with patient needs. The following excerpt signifies this:

The world has changed. What we are doing these days is extending people's lives far beyond what's sometimes reasonable. Euthanasia needs to be looked at - now more than ever (Russell, 2018).

This quote came from a hospice nurse who asserted that the dying process extends life “beyond what’s sometimes reasonable”. This could refer to family or patient requests to extend life as long as possible, or it could be interpreted as unreasonable medical interventions under the control of a doctor. This latter understanding constructs euthanasia as a way to wrestle control back from an unreasonably protracted dying process.

Another challenge to Medicine’s anti-euthanasia stand came from within the profession:

We failed her, I failed her, and I think I'm prepared to take a bit of flak for the fact that shouldn't happen (Walters, 2018a).

Lance O’Sullivan was heralded in the media as a “well-known Northland doctor” (Walters, 2018a) and “New Zealander of the year” (Nichol, 2018). In the quote above, when asked why he joined the #MyLifeMyChoice campaign O’Sullivan talked about the failure of fulfilling a young girl’s dying wish for euthanasia, placing the blame on himself and the

medical profession. Just as the Australian physician Nietzsche became an *unconventional hero* for challenging Medicine's refusal to support dying through euthanasia practice (McInerney, 2006), O'Sullivan is arguably represented as a local *unconventional hero*, although media representations of Nietzsche and O'Sullivan differ. Nietzsche was depicted as strongly critical of Medicine's refusal to participate in any legalised practice and he was intimately involved in euthanasia deaths, whereas O'Sullivan was represented as remorseful for letting a patient down by not relieving their pain and suffering, and did not overtly criticise other doctors. Nevertheless, associating a "well-known Doctor" with the pro-euthanasia campaign disrupted the power of Medicine's oppositional stance.

Generally, the State in the media was portrayed as open to enacting a law change if legalising euthanasia was the will of the people. This was created by multiple references to voting in favour of progressing the Bill at its first reading (Ngaro, 2018; Russell, 2018; Trevett, 2018; Walters, 2018b), and through the following two quotes from the pro-euthanasia, Member of Parliament, Louisa Wall:

To decide is human. To provide the ability to choose legally is Parliament's responsibility in a free society (Wall, 2018).

I believe we need to create a state-authorized mechanism to enable death for those who have been diagnosed with an incurable medical condition that becomes terminal when all state-funded treatments have been exhausted and the person, based on medical knowledge, has less than 12 months to live (Wall, 2018)

While research conducted in Britain portrayed the State as an outdated apparatus that failed its citizens and family members by disrupting their dignity in dying (Birenbaum-Carmeli

et al., 2006), the State in Aotearoa New Zealand was portrayed as the facilitator of choice that ‘individuals’ should be able to make in a “free society”. Euthanasia was thereby produced as a simple decision, no different from any other when living in a democratic society, drawing on the neoliberal notion of freedom of choice. The second quote above with its suggestion that a “state-sanctioned mechanism” for euthanasia should be made available for terminally ill people is an example of biopower, whereby through the Law and other regulatory processes, it is made possible for the State to control its population by manipulating biological features, such as mortality rates. What is absent from this construction is that social and cultural factors remove choice, and as such, not all people have equal access to State resources and quality healthcare.

This section has considered how Medicine, the Church and the State are portrayed in conjunction with the construction of euthanasia as a right and choice for the autonomous ‘individual’. Medicine is predominantly construed as out of date with patient needs and standing in the way of people’s choices in end of life decisions, while the Church is made villainous by creating fear that people could be euthanised for non-terminal conditions such as gluten intolerance. References to the State appear in favour of legalising euthanasia because living in a democratic neoliberal society demands freedom of choice. The next subsection discusses how the *autonomous right to choose* discourse is constructed to privilege the dominant group.

**A choice for the privileged neoliberal ‘Western’ subject.** Lyons and Chamberlain (2006) posited that wealthier groups conduct greater surveillance of their bodies and participate in practices to manage a ‘healthy self’. Therefore, it could be assumed that when illness (or disability) strikes, it is possible that this group is more susceptible to the influences of euthanasia as they can no longer maintain their healthy identity. In this analysis I argue that the construction of euthanasia in the Aotearoa New Zealand press acts on the desires and

motivations of predominantly middle to upper class, educated groups who have sufficient material resources, and who embody neoliberal values.

Those in favour of legalising euthanasia were portrayed in the media as ‘elite’ and holders of social and material resources. For example, across various media articles multiple references were made to Lecretia Seales’ legal battle to seek the choice to die with the support of her doctor. In these articles the nomenclature lawyer was presented, giving her an elite status (Nichol, 2018; Walters, 2018a; “Trial Underway”, 2018). Susan Austen was referred to as a chairwoman and former teacher, and although her legal fees were paid for via crowdfunding, the engagement of a Queen’s counsel in Austen’s defence added to the portrayal of Austen as well-resourced (“Daughter Knew” 2018; “Diary Plans” 2018; “Police Bug Home” 2018). Multiple references were made to Treadwell’s social and material privilege. We learn that her first husband was a diplomat (“Woman Accused”, 2018), she was intelligent, university educated, lived in many countries (“Diary Reveals”, 2018) attended music performances, and was “beautifully made up” (“Susan Austen Trial Verdict”, 2018). The quotes chosen below reflect the general tone of the stories in favour of euthanasia, which are stories of privilege:

This is a deeply personal issue for me as it is for many MPs. Four years ago, I sat by my mother's bedside ... While she had access to all the medication and nursing care you could ever want, she wanted the right to choose her own time (Young, 2018).

In Oregon, assisted dying is an overwhelmingly middle and upper-middle class phenomenon. The people that choose euthanasia in the United States are the people with health insurance and access to good palliative care (Walters, 2018b).

In first quote, the Member of Parliament Amy Adams described her mother as having

material resources and palliative care, but what was lacking was her “right to choose”. In the second quote, Seymour distances euthanasia from the ‘vulnerable’ by informing readers that euthanasia is a “middle and upper-middle class phenomenon” which I take to signify a group of people with wealth, education, managerial/profession roles, and social power. These portrayals enable at least two things, they divide euthanasia from the working class and those of low socioeconomic status, and they suggest to the middle and upper classes to view euthanasia as an acceptable end of life choice. Critically, in focussing the discussion away from the needs of people who are vulnerable, other important issues such as equal access to quality healthcare and material resources are hidden.

Non-dominant cultural ideals and values that might matter to euthanasia are underrepresented in the media. Although Lance O’Sullivan is mentioned in one article as being Māori (Walters, 2018b), what ‘being Māori’ might mean to euthanasia is not questioned. Whether this is because what it means to be Māori is a contested concept (see Houkamau & Sibley, 2010), and therefore too complex for the euthanasia debate as presented in the media, or whether O’Sullivan himself chose not to offer his thoughts on the issue; the absence of any consideration Māori cultural ideals is striking.

The aspects drawn out above that supported the *autonomous right to choose* discourse were not however without contest. Members of Parliament, a Christian bioethicist, the Disability Commissioner, and various health professionals proffered views that challenged this construction on the basis of ethics, concerns for patients and society in general. These challenges are analysed next.

## Counter Discourse: Perilous

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Whether a news article was for, against, or neutral about the topic of euthanasia was inferred by reviewing its general timbre. Across the 45 articles analysed, nine articles had an anti-euthanasia character representing euthanasia as a *perilous* choice. This I have called a “counter discourse”, however, in line with Foucauldian thinking, this is done with the acknowledgement that social power relations are perpetually asymmetrical and therefore margins for resistance are limited (Yates & Hiles, 2010). Nevertheless, the *perilous* discourse has the potential to unsettle the construction of euthanasia as the *autonomous right to choose*.

**A perilous choice for society.** In contrast to the prevailing discourse which centred on the ‘individual’, their decisions, rights, and choices - the construction of euthanasia as *perilous* focussed on the relationship between a person and their community, where protecting the community, and in particular people positioned as vulnerable was paramount. Malpas et al. (2017a) likewise noted in their mainstream research that those opposed to euthanasia assumed a collective responsibility over the needs of an ‘individual’. In the *perilous* discourse, euthanasia was constructed as a practice that impacts negatively on the vulnerable in society, and devalued the life of people considered disabled or elderly. The term vulnerable was used in the media in two ways, it was either left open for interpretation, or it referred specifically to the classic vulnerability categories of elderly or disabled.

In the following extract, Dr Kleinsman, a Catholic bioethicist, highlighted the risk of legalised euthanasia acting in a “coercive” manner on the elderly and disabled. This sentiment was echoed in the second example below which referenced the views of Member of Parliament Maggie Barry:

“The biggest danger is the subtle coercion,” says Kleinsman, that somehow, elderly people do not have a place in our society anymore; that people with disabilities who are dependent don’t have a place in our society (Walters, 2018b).

MP Maggie Barry, the former Minister for Senior Citizens, sees liberalisation as an “inevitable outcome” of the legislative process - a conveyor belt of human misery on which we will eventually load the burdensome elderly, disabled and, yes, children. (Walters, 2018b)

Kleinsman draws attention to how ageist and ableist thinking might negatively affect a person’s sense of worth, and the use of the “subtle” brings to mind the hidden and insidious ways “society” acts on people who no longer “have a place”. The concept of ‘absolute sovereignty’ over the body, or ‘pure autonomy’ is thus challenged as this *perilous* discourse suggests bodies are acted on by subtle negative forces. “Liberalisation” as the “inevitable outcome” of legalising euthanasia infers that the EOLC Bill criteria will be extended over time, putting more people at risk and when coupled with the metaphor “conveyor belt” suggests a thoughtless mechanical process without due care, conjuring up images of those who are dependent being shipped off to an involuntary death. However, the idea that some groups are subject to subtle coercion is met with counter resistance:

He [David Seymour] says the people who take the option overseas are not the vulnerable or those on the fringes of society. Quite the opposite, in fact. (Walters, 2018b).

Here readers are reminded that it is not the “vulnerable” or those on the “fringes of society” that enact euthanasia. This counter resistance to the *perilous* discourse supports my assertion that those with social power, for example, the middle or upper class, white, educated ‘Western’ subject with material and social resources are more likely to take up euthanasia. However, the idea that euthanasia is *perilous* for elderly and disabled people is amplified through the media.

**Perilous for the disabled.** Readers were informed that Kylee Black, once able-bodied, has a progressive and incurable medical condition, which has “confined [her] to her wheelchair” yet in spite of this, she “does not give up” on life (Akoorie, 2018). While using the term “confined” creates an image of someone without freedom, overall, Black was fashioned as someone with the authority to speak about the perils of euthanasia:

Black does not want to die. And she does not want doctors suggesting death as an option to her, especially on her darkest days... “We all have times of struggle. We all grieve... we can go on to find meaning and quality in life again, despite the struggles that we may face each day” (Akoorie, 2018).

In the extract above, Black inferred decisions related to death arise through interactions with others, and in this case, through the interaction with the medical profession. Not only does this disrupt the prevailing discourse that constructs euthanasia as the choice of a fully autonomous person acting without the influence of others, euthanasia is made dangerous by highlighting the mutable characteristics of moods and emotions that act upon our subjectivities. Overall, in this counter discourse, euthanasia is construed as *perilous*, open to influence by others, and decisions about euthanasia are depicted as transitory. Attempts to portray the disabled body focussed on the physical pain and suffering endured and Kylee Black as a *stoic*

*hero* battling to stay alive. In the same article, Black goes on to say that the message behind the EOLC Bill puts the disabled body at risk of coercion:

People are better off dead, than disabled. Some people will be more vulnerable to external circumstantial pressures, and this is putting them at further risk rather than supporting them. How is that a fair, individual choice? (Akoorie, 2018).

This second extract coheres with previous studies that challenged euthanasia laws for sending messages to the disability community that they are better off dead than disabled (Haller & Ralph, 2001; Schwartz & Lutfiyya, 2009). In the *perilous* discourse the media also assert that a body outside of the norm is not reason enough to engage in the practice of euthanasia.

The construction of euthanasia as *perilous* also enabled disability advocates to underscore the existing inequities facing the disabled community in Aotearoa New Zealand:

Before the country legislated choice in death, it needed to work towards ensuring, to the greatest extent possible, all people had the same freedom of choice in life (Akoorie, 2018).

In the quote above, the Disability Rights Commissioner Paula Tesoriero pointed out the power of context in limiting choices, highlighting that there is inequality in “life” choices that should be addressed before “choice in death” is legislated. The neoliberal notion of ‘freedom to choose’ is implicitly challenged as euthanasia is portrayed as a Clayton’s choice, that is, not a ‘real’ or actual choice. This construction suggested disabled people do not have equivalence with non-disabled people in choices across the life course, such as meaningful work, adequate housing, innovative and assistive technologies, and such like.

Absent from the *perilous* discourse was the notion that living in an impaired body was something that could be celebrated. Instead disability was presented in a stereotypical fashion with stories of physical impairment such as Black (above) and media images of wheelchair bound people. Alison Kafer refers to this stereotypical portrayal of disability as the “ableist failure of imagination” (Kafer, as cited in Fritsch, 2015 p. 44). So, while the *perilous* discourse seeks to protect disabled people from coercion, it falls short of affirming a life where living with a disability could be imagined as a life worth living.

Furthermore, the labelling of aged and disabled groups as vulnerable in the *perilous* discourse fixes vulnerability to a person because of certain ‘essential’ characteristics, and in doing so, people are placed in a hierarchy against those who are young, healthy, strong, and non-disabled. Although likely not intentional, by demarcating such groups as vulnerable to coercion and undue influence, it reaffirms negative stereotypes. Many older or disabled people live in supportive family/whānau structures, where interdependence or dependence are socially acceptable practices.

In summary, the prevailing discourse of autonomous right to choose located in the media constructed euthanasia as a decision to be taken alone without the influence of others. That euthanasia should be an end of life choice was taken-for-granted as a human right. The mentally ill were excluded from enacting suicide in this discourse through the separation of the sane/rational from the insane/irrational. Cultural ideals and values supported a privileged Western subject over non-dominant groups. Both the Church and Medicine were portrayed in ways that diminished their power over moral and ethical issues related to dying. A reading on the counter discourse of *perilous* was offered that suggested euthanasia was dangerous for society, and particularly dangerous for the disabled person. The next section considers the subject positions that arose from reader engagement with the media articles.

### **The Subject Position of My Choice and Mine Alone**

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The *autonomous right to choose* discourse made available two subject positions for readers to take up, which I have called *my choice and mine alone* and *the defender of rights*. In this part of the analysis I was interested in how power circulates through these positions; how readers took up specific subject positions, and what opportunities for action were opened up, or closed down by the subject positions. I also considered what could be felt, thought and experienced from within the subject positions.

In the media, the discourse of *autonomous right to choose* produced euthanasia as a legitimate end of life choice to be enacted by an autonomous ‘individual’ as their human right. Taking up the subject position *my choice and mine alone*, enabled readers to claim euthanasia as a rational choice outside of the influence of other people, and a choice that should be permissible regardless of any potential negative impact on other people.

Many readers expressed strong emotions, spoke assertively, and at times conveyed anger about what they perceived to be a decision that they alone could, and should, be able to make. In the quote chosen below to represent this sentiment, Caelan’s<sup>18</sup> account conveys a sense of frustration at a system that denies a person the ability to make “make up their own mind” about euthanasia, and by using the phrase “butt out” those opposing euthanasia are firmly told to stop interfering:

How about just letting me make up my own mind on my end of life choices. It's nobody else's business. I say butt out of my life and its ending (Caelan).

I want to be able to make this decision while I still have my faculties and can make a rational call (Caelan).

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<sup>18</sup> As mentioned in Chapter 4, readers are provided with fictitious names.

Holding this subject position supported media assertions that decisions to carry out euthanasia required mental competence, and that euthanasia required a “rational” understanding of the consequences of such a decision. This is expressed by Caelan in the second excerpt above.

Occupying the subject position of *my choice and mine alone* required a belief that there were sufficient “safeguards” in the proposed EOLC Bill that would protect others from harm:

There are many safeguards to its misuse written in. And it is totally about personal choice...It is about allowing you and me the possibility of choosing to die well when the need arises (Maia).

They make it sound as though people will be forced to euthanise themselves. No one will have to die and everyone will make their own choice as to whether they continue their suffering or not (Hunter).

Maia refers to “personal choice”, drawing on the prevailing discourse and its individualistic construction of euthanasia. The subject position of *my choice and mine alone* provided access to the possibility of dying well, and implicit within this was the idea that by choosing euthanasia, a death with dignity was within an ‘individual’s’ control. Hunter similarly expressed the idea that choices about euthanasia are personal and able to be made without coercion as no one will be “forced to euthanise themselves”.

**Wrestling control from the Church and the State.** To claim the subject position of *my choice and mine alone* readers were required to reject interference in end of life decisions

by the Church and the State, and did this by asserting that “life” did not belong to any institution:

A person's life doesn't belong to a religious group (Tatum).

And should not belong to the State as is the case at present (Max).

Here, Tatum stresses that “life” does not belong to a religious group and Max infers “life” currently belongs to the State. These arguments work together to wrestle control of the body from the Church and the State into the realm of ‘individual sovereignty’ in matters related to life and death.

Within the online comments there was some resistance to the argument that life belonged to the ‘individual’ as noted in Sage’s response to Tatum and Max. Sage attempted to disrupt the dominant understanding by asserting life “belongs to God”:

You are right; it belongs to God (Sage).

For people such as Sage admonishment was swift. Those who expressed religious views were constructed as Other. This was done by positioning people who held religious views as insane and irrational:

If you allow religion into the debate, common sense is immediately excluded.

Religion or reality; you can't have both (Max).

... the Churches viewpoint doesn't have any relevance anyway. Feel free to argue against it as an individual using a rational argument (good luck) but keep your faith out of our laws (Reagan).

Perfectly stated. Couldn't put it better myself. I say my life, my choice. Certainly, no business of the religious nutters spewing forth their moronic garbage (Dana).

In the quote above, Max draws on a scientific paradigm that honours objectivity over faith-based arguments, thus denying people entry to this subject position who draw their thinking from religious belief systems. The quote by Dana echoes similar sentiments, as people who professed faith-based arguments were derogatively positioned as “religious nutters”. Overall this discursive exchange worked to silence those with faith-based or religious views.

Interference by the State or anyone opposed to euthanasia was also rejected. Rebutting the *perilous* discourse conveyed by “politicians and do gooders” that euthanasia is dangerous to the society, Caelan asserted euthanasia to be *my choice and mine alone*:

I don't need politicians and do gooders influencing my choice and mine alone (Caelan).

**Wrestling control from Medicine.** Medical control of the body also featured in the *my choice and mine alone* subject position. Here, there was considerable manoeuvring around a wide range of ideas about the role of medicine. Some readers referred to the classic concept of a prolonged medicalised death, challenging others to think about who benefits from a protracted dying process. A number of readers raised issues about the side effects of morphine, and made pleas for the consideration of medical cannabis as an alternative drug that would allow those with sickness to retain awareness of who they were:

Morphine is a shocking drug, changes a person's personality, it's short acting and as you have pointed out the dosage has to be constantly increased. I don't know why the medical profession push that as there are alternative long acting medicines out there with fewer side effects. Even medical cannabis would be a far better alternative (West).

Explicit in the text above, West called out the “pushing” of morphine by the medical profession and its deleterious influence on a person's sense of ‘self’. It is possible to read Medicine's continued use of morphine as an outcome of social power whereby, the main focus for the doctor is biological symptom management, whereas, the subject desires control over both physical pain and mental acuity. That “medical cannabis would be a far better alternative” and is yet not a choice people can currently make highlights the power of Medicine and pharmaceutical companies to construct socially sanctioned drug use.

What mattered in holding the subject position of *my choice and mine alone* was allowing people choice and control over their bodies:

Maybe the focus should be on allowing people to do what they want with their bodies when medical science is failing them, and they are in severe pain, and allow pentobarbital to be prescribed. Whether people then choose to use it, and die peacefully should be a matter of personal freedom (Frances).

Frances does not reject Medicine's support in the dying process outright, but highlights that Medicine can fail people. In this way, euthanasia is represented as end of life choice as a matter of “personal freedom”.

A few readers suggested the issue of euthanasia was of national importance and required a referendum. When it came to occupying the subject position of *my choice and mine alone*, the power of Medicine to stand in the way of legalising euthanasia was viewed as something that could be challenged by the exercising of ‘democratic rights’:

... please remember medical professionals while your opinion is important and valid you do not speak for all New Zealanders. This decision needs to be made via referendum at an election... Let all Kiwis decide if this is something we want (Val).

In summary, the subject position of *my choice and mine alone*, pushed back against religious views and Medicine’s role in end of life decisions that produce the ‘individual’ in control of choices related to their body. In this way, euthanasia was portrayed as the ultimate act of ‘individual’ autonomy. This subject position has the hallmarks of what Douzinas (2013) called a self-centred sensibility that posits choice as the right of free-thinking neoliberals. For those holding this position, sufficient safeguards to protect the ‘vulnerable’ were thought to be in place, and there was little consideration that others might not be free from coercive practice and undue influence. Notwithstanding the historical and cultural specificity of other research which necessarily impacts on how euthanasia is taken up, this subject position shared similarities with earlier research that favoured euthanasia as strong willed, independent and self-determined (Birenbaum-Carmeli et al., 2006). From the *autonomous right to choose* discourse, a second subject position arose, *the defender of rights* and the next subsection explores this.

## The Subject Position of The Defender of Rights

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While in the media, human rights were spoken of across multiple articles, most of the negotiation of the subject position *the defender of rights* took place following an article that outlined the concerns of the Disability Commissioner<sup>19</sup>, and centred on disability rights. To take up the subject position of *the defender of rights*, it mattered not if you were disabled or non-disabled, terminal or non-terminal, all of this was secondary to exercising human rights which were understood as something to be equally applied regardless of the variability of embodied experiences.

Drawing upon the notion of rights, Easton and Kaden in the following extracts claimed that euthanasia should be universally available. Easton shared his/her experience of disabled people historically advocating for the same rights as non-disabled people, and queried whether this should be any different in death:

In my experience, people with a disability have been advocating for the same rights in every part of life for years, why should that be different for death? (Easton).

In a democracy, choice and options are supposed to be a good thing - why are there some who would try to undermine that democratic choice? (Kaden).

Past practices of advocating for disability rights over the body in “life” were argued by Easton as ‘evidence’ that rights over the body in “death” are the same issue. This quote conveyed a feeling of solidarity and progressiveness representing the role of a moral crusader (within *the defender of rights*) for those less fortunate. Constrained within this view was any

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<sup>19</sup> Concerns related to processes such as informed consent, capacity to make an informed choice, and safeguards to determine if coercion existed (Walters, 2018a).

critical evaluation as to whether rights “in life” for disabled people have been met in practical terms. Kaden professed “democracy and choice” to be a “good thing” positioning those who opposed euthanasia as restricting the democratic rights and freedom of others less fortunate. It could be argued that Kaden drew on democratic ideals which assume concern for the community, when our orientation is actually towards acting for our own self-interest (Shildrick, 2015).

Stereotypical representations of disability such as, being a tetraplegic or in a wheelchair, dominated readers hypothetical expressions about disabled people’s rights to euthanasia. In the quote chosen to represent this below, Finlay assumes they know what it means to live in a disabled body and how living with disability would result in them wanting the option for euthanasia:

If I was severely disabled or a conjoined twin I would want that option (Finlay).

Finlay evokes an image of a person “severely disabled”, or a “conjoined twin” who by right should have the option to die. This image has the potential to conjure up sympathy, possibly fear and abhorrence at a body that is not considered ‘normal’ or ‘healthy’, and take on a moral form similar to that seen in Crawford’s (1980) healthism discourse in that we are ‘individually responsible’ to perform ‘health’. When thought of like this, *the defender of rights* subject position facilitates an insurance policy against future disability in that undesirable lives can be ended. Living with “severe disability” or as a “conjoined twin” is not considered a life worth living.

While more than 200 readers engaged with the various stories open for comment, only four people self-identified as disabled which means that in this thesis few readers claimed the label disability for themselves. While it cannot be known if there were more disabled people

commenting, it can be reasonably surmised that many people spoke on behalf of disabled people. This suggests disability rights were co-opted by non-disabled readers which had the effect of privileging the rights of the non-disabled without consideration of negative impacts on those unable to exercise rights, and without concern for addressing current injustices incurred in the disability community where current rights remain unrealised.

**Ageing and mental competence.** In occupying the subject position of *the defender of rights*, it was morally and ethically permissible for an elderly body to die by euthanasia. In the introductory chapter I outlined the negative portrayal of ageing in Aotearoa New Zealand due to the high numbers of those born between 1946 and 1964 (Jackson & Cameron, 2017) who are colloquially known as ‘baby boomers’, and considered by some as a drain on economic resources. The comments below by Ray and Blaine are expressions of this line of thought:

We have an ageing society in an already over populated world, why oppose those with valid reasons to end their own life and die on their terms (Ray).

Could be tweaked in the future to include whittling down the baby-boomers. Seemingly, the young regard them as Public Enemy #1 (Blaine).

In Ray’s comment above, the so-called ‘ageing society’ problem can be addressed by allowing older adults the right to die. This outlook is also implicit in Blaine’s comments. In a world that already stigmatises older adults, this commentary positions older adults as the problematic Other and conflates ageing with euthanasia, as similarly seen in McInerney’s (2007) Australian research. The aging body was considered expendable and not worthy of defending.

Calling attention to the “sound”, and “sane” person who has “genuinely” considered euthanasia, implicit within Tanner’s comment below was that the rights of disabled people to euthanasia included those with a physical and/or sensory disability, but not the disabled person who was irrational or insane:

It is discriminating against disabled people to not be allowed the choice given strict criteria and all other options to improve their lives have been exhausted. There will be a small (very small) number of them who genuinely want to die for very sound and sane reasons (Tanner).

By taking up this subject position, a person is afforded the opportunity to appear socially just and progressive by advocating for disabled people’s right to die. As expressed in the comment by Ray above in relation to the aged body, and here by Tanner in relation to the disabled body, the person whose rights that required defending were those who could make “valid” and rational reasons to end their lives.

In summary, *the defender of rights* subject position was available to those who subscribed to the idea that all humans should be treated equally, regardless of their embodied experiences of health, illness and dying, unless that body belonged to the person who was older. The disabled body was portrayed in a way that privileged a non-disabled understanding of disability, and the ageing body was rendered a waste of resource. As Douzinas (2013) argues the construction of ‘human rights’ serves not the unfortunate, but the dominant groups and ignores economic and social specificity. In this way, the subsuming of disability rights constrains the attendance to social justice issues and took attention away from the serious inequalities in health access that persist between genders, generations, ethnic and socioeconomic groups. Both the *my choice and mine alone* and *the defender of rights* subject

positions facilitate and limit can be said, by whom, where and when, and are made possible by the *autonomous right to choose* discourse. The next chapter unpacks another dominant discourse that was located in the media; *escape from pain and suffering*.

## Chapter 6: Escape from Pain and Suffering

Unlike the prevailing discourse of the *autonomous right to choose* which focussed on the body in terms of sovereign rights, in the secondary discourse of *escape from pain and suffering* discourse, the central concern related to the presence of prolonged physical pain which was represented as the primary justification for euthanasia. In this chapter, the notions of escaping from physical pain and mental and social suffering, and the losses associated with ageing which acted to justify euthanasia are analysed with consideration of literature. A counter discourse of *unnecessary* is also discussed. Finally, the subject position of *getting out* which arose from the *escape from pain and suffering* discourse as represented in the readers' comments to media posts is unpacked.

### The Escape from Pain and Suffering Discourse

**Escaping pain.** Stories of Treadwell's physical pain featured extensively in media accounts and acted to legitimate euthanasia. The following extracts provide examples of the portrayal of Treadwell's physical health status:

She had sore hips and jaw ("Woman Not Guilty", 2018).

Arthritis was crippling her hands and starting to affect her feet ("Trial Verdict", 2018).

She lived with constant pain in her fingers, toes and hips ("Diary Plans", 2018).

[She] was not terminally ill, but she was plagued with pain and ready to die ("Comfort Drug", 2018).

Many representations about Treadwell's pain were taken directly from her personal diary. This penchant for voyeurism, the looking in at people's pain and distress for

entertainment purposes was noted by Seale (2010) to be a media tactic that aids selling of news and dilutes the complexities of ethical debates. It could be argued that these depictions of Treadwell “sore”, experiencing the “crippling” effects of arthritis, and living “with constant pain” acted to make her a martyr for the euthanasia cause, and death by euthanasia an acceptable means of releasing the body from pain. A similar articulation can be found in Birenbaum et al. (2006) British study where those crippled and pain-racked participated in euthanasia to leave behind their failing bodies. Furthermore, that Treadwell was “plagued” with pain conjures up a negative illness metaphor that suggests a catastrophic health status, and something to escape from. What is interesting here is that unlike other research, such as that by Hausmann (2004), where the British press represented terminal illness as the justification for euthanasia, terminal illness did not act alone to legitimate euthanasia. Treadwell “was not terminally ill”, and nor were a number of people who spoke in favour of legalising euthanasia. Physical pain in the justification of euthanasia was thus superordinate to terminal illness.

Experiencing physical decline was portrayed by the media as a foreboding future. In the following extract, Treadwell had “given up riding her bike”, and walking was difficult “even with walking poles”:

At the time she wrote she had recently given up riding her bike. Treadwell loved walking, but by that stage, even with walking poles, she could last for 40 minutes at most (“Diary Reveals”, 2018).

Alongside references to Treadwell as an elderly woman, this representation is consistent with previous literature that positions ‘healthy ageing’ as the norm, and loss of functional decline as abnormal (O’Rourke & Ceci 2013). The depictions noted above are

arguably an expression of self-surveillance as Treadwell appears to have monitored the health activities and the duration of the exercises she undertook.

In the media there were many references to Treadwell's pain management practices which rendered her a self-disciplined person who participated in various treatment plans. These treatments however appeared to insufficiently address Treadwell's pain, and the traditional role of Medicine as a healer was thus challenged:

The diary recorded that Treadwell thought her doctor believed she was much better than she was..., but she lived with constant pain in her fingers, toes and hips ("Diary of a Death", 2018).

...she thought she found someone [Austen] who understood, someone who "accepted my view of my case" ("Diary Reveals", 2018)

The patient's subjective experience of living in "constant pain" which was "accepted" and "understood" by Austen, a non-health professional, further disrupts the traditional patient/doctor relationship where the doctor's assessment of the patient's health is the commonly accepted view. Braude (2014) refers to this problematic of Medicine as the "limits of cure" that exist when people with chronic illness (such as Treadwell's arthritis) do not respond to powerful pain management (Braude, 2014, p. 266). In Treadwell's case, the media representations of her constant pain despite medical treatment worked to portray Medicine at the end of its limits, and euthanasia the cure. Whereas in the *autonomous right to choose* discourse, Medicine was challenged in relation to its decision-making power over the body, in the *escape from pain and suffering* discourse, this media portrayal disrupts the role of the doctor as a healer.

Euthanasia was portrayed in the media as a painless, simple and quick death, and a way to escape a painful, violent, tragic or prolonged death:

O'Sullivan's decision to support the bill was shaped by the time he spent with a young patient with a terminal illness. It was a painful death, and she wanted to be able to control how she exited the world (Walters, 2018a).

The death of O'Sullivan's patient was "painful", was coupled with reports in the media that Seales wanted to avoid a "painful death" (Nichol, 2018). Added to the portrayal that death without euthanasia is painful, was the invocation that death by euthanasia was simple and quick. In a story about Nietzsche's euthanasia death pod – readers were informed you simply "choose to press a button" and "rapidly" lose consciousness and die (Erikson, 2018). Death by suicide was on the other hand portrayed as violent and tragic:

This is a situation where one person chooses to press a button ... and then will feel a bit dizzy but will then rapidly lose consciousness and die... rather than, for instance, standing in front of a train (Erickson, 2018).

I had a patient a few years ago who died a horrible death, and her lovely husband just couldn't cope so he hung himself... This is how elderly people are killing themselves (Russell, 2018).

The quick ending to life suggested in the media image of the euthanasia death pod was starkly contrasted against the tragedy of a violent and messy death experienced by "standing

in front a train”. The second quote similarly depicts death by suicide as tragic through reference to elderly people “killing themselves” to escape a medicalised “horrible death”.

While physical pain was constructed as the primary justification for euthanasia, pain was simultaneously produced as an object within the control of a person, provided they had the power to end life. This idea was captured in the statement read at Austen’s trial defence, where end of life issues Clinical Psychologist and Professor Glynn Owens purportedly informed the court that:

...there was a profound effect of reducing physical and psychological suffering by having the power to end life. A reduction of anxiety led to reduction of pain, and a sense of being in control could reduce stress. The prospect of a good death could lead a patient to focus on the quality of life (“Austen Trial”, 2018).

This statement can be read a number of ways. This understanding has the potential to make those unable to manage their pain, somehow responsible for their pain. It can also be interpreted as a threat to medical power, and a privileging of psychological knowledge. Moreover, by having access to euthanasia drugs, it is possible to escape physical suffering and have the “prospect of a good death”. In contrast with McInerney’s (2007) research that claimed the Australian press constructed the euthanasia death as a “beautiful death”, with the dying slipping off peacefully into death, the overall construction of the “good death” in the Aotearoa New Zealand press is one that is, painless, simple, and quick.

**Escaping mental suffering.** In the *escape from pain and suffering* discourse, mental suffering was marginalised. Paradoxically, Treadwell participated in euthanasia *and* she had a clinically diagnosed mental illness, yet little attention was paid to her mental state in the media. Birenbaum et al. (2006) highlighted a similar finding in the British press where the mental

capacity to choose euthanasia was not challenged. Notably, any mention of depression appeared alongside accounts of physical pain, obscuring the role depression may have had in Treadwell's euthanasia:

By the time she wrote to the select committee she was on a steady diet of painkillers for the arthritis that had crippled her hands, and was now spoiling her feet, and perhaps her hips. She was annoyed that it made her clumsy and embarrassed when she dropped things in public. In the gloomy months of the year, seasonal affective disorder overlaid the clinical depression she suffered ("Diary Reveals", 2018).

Readers are informed about Treadwell's physical condition and her "steady diet of painkillers" and that she wrote to the "select committee" in support of legalising euthanasia, thus further positioning her as a *tragic martyr* for the euthanasia cause. The psychological constructs "clinical depression" and "seasonal affective disorder" (SAD) were presented as if commonly understood, yet, neither term is without issue. As previously mentioned, the term depression is a contested category (Davis, 2013). Moreover, the idea of a depression affected by the weather was recently portrayed as 'folk psychology' due to poorly validated assessment tools (Traffanstedt, Mehta, & Lobello, 2016). These challenges to the construction of categories remind us that terminology is not static, yet in the discourse of *escape from pain and suffering* they are portrayed as 'scientific truth'.

As mentioned previously, a negative framing of old age has given rise to a new norm that ageing occurs without cognitive decline (O'Rourke & Ceci, 2013). Short-term memory loss was portrayed as something that not only makes a person less efficient, an issue in a neoliberal society that values efficiency, but something that leaves a person "embarrassed and frustrated", and a loss that "saddens" family members:

The occasional "senior moment" had developed into short-term memory loss. She wasted time looking for her keys, and forgot appointments. "This leaves an intelligent person like myself feeling embarrassed and frustrated."..."My daughter, who has noticed these lacunae, as well as other signs of deterioration is appalled, and so sad" ("Diary Reveals", 2018)

To experience such feelings and emotions requires an assessment of a 'self' against a set of standards, which place value on 'normal' mental health. It is possible in a different social and historical context that short-term memory loss could be construed as acceptable in older age, and would not be met with sadness, but with compassion. Knowing Treadwell died by euthanasia, this extract also offers euthanasia as a prescription for how people can govern themselves in older age to reduce the "sadness" for family members left behind. When portrayed in this way, euthanasia could be considered a 'technology of the self' as argued by Birenbaum et al. (2006) practiced to stem mental decline.

**Escaping social suffering.** The fear of dependence on others due to incontinence, and the concomitant notion of being a burden were the primary illustrations of social suffering assembled in the media. This understanding aligns with the Australian press construction of incontinence as degrading and a powerful justification for euthanasia (McInerney, 2007). In the Aotearoa New Zealand media, independent personal care was also positioned as the norm, and incontinence something to be feared. The following two quotes are examples of the way incontinence was constructed. In the first example, we return to an interpretation of Treadwell's diary. As we do not know if Treadwell was incontinent, in this passage, all that can be inferred is that Treadwell feared future incontinence. In the second quote, one of the #MyLifeMyChoice

campaign front people marks being “dependent on the care of others” as the point at which he should be “allowed to die”:

She didn't want to be a burden on her family, having them dread phone calls about accidents and mishaps (“Diary Reveals”, 2018).

... his future would entail a deterioration eventually leaving him bedbound, dependent on the care of others. At that point, he wanted to be allowed to die (Nichol, 2018).

Applying a neoliberal lens of Responsibilisation to the two extracts above suggests that risk of dependence on others dictates a social response of euthanasia. In this discourse of *escape from pain and suffering*, responsible citizens with knowledge about how to avoid dependent care, manage their own healthcare and dying process by enacting euthanasia. Concerns around loss of bodily control were reinforced by a former hospice nurse:

I have seen patients who cannot control their bowels or bladder, who can barely move, and who are unable to communicate with their families. I see voluntary euthanasia as a way to relieve those people of that suffering if they choose - and to die with dignity (Russell, 2018).

Voluntary euthanasia is represented as the way to preserve the “dignity” and relieve “suffering” of those who are incontinent and experiencing other disabling conditions. Discourses of dependence that feature in the media with incontinence in particular are said to create a stigmatising condition, yet incontinence is an everyday reality for many disabled people (Newell 2006), and not considered demeaning in other cultures (Lamb, 2014). This

construction in the Aotearoa New Zealand press has the potential to stigmatise those who require assistance with personal care activities, and diminish cultures where interdependence is the norm. In a similar vein to the findings by Haller and Ralph of media analysis undertaken in the United States and Great Britain (2001), euthanasia was equated with dependency. Additionally, in Western society, incontinence is said to be associated with a fear of ‘dirty dying’ and bound to the “possession of a physically bounded body” (Lawton, 1998, p. 131). Thus, it could be argued that euthanasia is presented as a way to avoid a ‘dirty death’.

Social experiences of ageing were negatively portrayed in the media through repeated references to Treadwell’s diary:

Looking after the frail elderly well meant consigning them to years of nothingness, with little joy and no hope, she said. "NO longer do their house, garden, clothes, membership of a church or clubs affirm who they are or were; they're now just vulnerable "little oldies", with grey hair and glasses, having lost their individuality (“Diary Reveals”, 2018).

"My world is shrinking and I feel myself becoming boring and pitiful... and - once again - I feel foolish in company whereas before people would be keen to hear my input!" She felt as she got older she had become invisible, or was treated like a clueless child (“Diary Reveals”, 2018).

Experiences of ageing seemingly stripped a person of “joy”, “hope” and “individuality”, and contributed to an older persons experience of “invisibility”. It appears from this text that Treadwell herself may have experienced ageist stigma, and was influenced by an ageist discourse. Using the term “frail elderly” in this way, constructs the older adult as a

homogenous group, ignoring the many different experiences available to people, and the layers of vulnerability people are exposed to across the life course. These representations of ageing align with McInerney's (2007) Australian press images of residential aged care facilities whereby older adults were produced as unproductive and having lost their 'personality'. This portrayal of ageing in the media has the potential to induce fear of ageing. In this way, euthanasia is presented as a risk management strategy to protect against losses associated with ageing by hastening the biological death in order to avoid the social death (Seale 1998, p. 183) of living in residential care.

Across portrayals of physical suffering, mental suffering and social suffering was a distinct absence in the media of any non-Western understandings of health or health models or alternative cultural values such as reciprocity and interdependence that may challenge the dominant negative understandings of dependence and burden (Lamb, 2014, Ranzijn, 2010). This absence of alternative perspectives limits what is possible to think about the relationship between, healthy bodies, age, and euthanasia.

### **Counter Discourse: Unnecessary**

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Euthanasia as an *escape from pain and suffering* was met with moderate resistance. Mainstream research informs us that fear of pain by both the public and patients influences pro euthanasia engagement (Danyliv & O'Neill, 2015; Hendry et al., 2012; Rae et al., 2015). This theme played out in the media with euthanasia presented as a way to alleviate pain and suffering. However, whereas it might be assumed that a counter discourse to *escape from pain and suffering* would centre on allaying fears of pain, the counter discourse of *unnecessary* did not argue that pain could be obliterated. Instead, this discourse represented symptoms as manageable through medical advancement and constructed death under palliative care as a "gentle death":

"It converts killing into a form of healing and doesn't acknowledge that we can now do more for symptoms through palliative (care) than ever before," Sulmasy said (Erikson, 2018).

Hartfield is adamant palliative care can help everyone. "In all my experience, I have never met anyone who has suffered from all these terrible things that are being talked about, which by the way is making the public very scared of dying." He said palliative care offered comfort, a gentle death, relief of symptoms, spiritual care and care to relatives and a bereavement service (Russell, 2018).

The first statement by Sulmasy (a palliative care specialist) that euthanasia is "killing" can be read in a number of ways. One interpretation is that death by euthanasia is criminal. It could also death by euthanasia is violent or involuntary. When coupled with the idea that symptom management under palliative care is advancing, euthanasia is rendered unnecessary. The second excerpt relates to the views of a former palliative care doctor and further represents symptoms as manageable, and death under palliative as "caring", "comfortable" and a "gentle death".

Unlike other critical research that noted the absence of any real dialogue with people or interest groups opposed to euthanasia (Birenbaum-Carmeli 2006; McInerney, 2007), palliative care perspectives such as those above, and in another article entitled "Hospices will not euthanise" (Manch, 2018) were present, along with the use of nomenclatures of Professor, Chair, Specialist and Doctor, all signalling expert status and raising the credibility of the opinions offered by these medical specialists.

While death enacted by euthanasia was portrayed as simple, quick and painless in the *escape from pain and suffering discourse*, this notion was challenged directly in the counter discourse of *unnecessary*:

Euthanasia is not 100% dignified, some take the drug and vomit it up or wake up four hours later ... about 7% will have some sort of complication (Russell, 2018).

In the passage above, the notion of dignity which is ordinarily associated with pro euthanasia depicts death by euthanasia as potentially undignified. Furthermore, the suggestion that a person might “wake up four hours later” contests the representation of euthanasia as a quick death. Equating “vomiting” with a loss of dignity is however a particularly Western notion, as with incontinence. As previously argued, other cultures do not attribute negative values these bodily processes and as such, it would not impact upon loss of dignity (Lawton, 1998).

The counter discourse of *unnecessary* was also built on the idea that palliative care was for everyone:

There’s a large cohort of people who are dying of heart failure, respiratory disease, dementia – in particular – who don’t ever get referred to palliative care services (Manch, 2018).

The real solution is to ensure all whānau and families across Aotearoa have access to world class palliative care to ensure that we can ease the passing of our loved ones. This would also ease the burden of care that falls on whānau so as not to cause any

artificial or premature end of life. Then, and only then, we will have truly succeeded (Ngaro, 2018).

The discourse of *unnecessary* worked to produce palliative as ‘necessary’ provided the dying could access the “world class” system. That palliative care is not accessible to everyone, such as those living in regional areas, did not feature strongly in the media, again ignoring sectors of society without appropriate health care. While comments such as those above acknowledged gaps in care, they did not seek an alternative model of care, nor attend to cultural nuances, thus implicitly claiming palliative care to be the process under which death *should* be managed.

The construction of euthanasia as the solution to escaping age related mental and physical decline was contested. In a rare display, one opinion piece challenged the notion that the process of ageing itself was to be feared:

Most older people I know, like me, forget names, lose their keys, and fairly often can't find things they know they put somewhere. They have aches and pains and don't enjoy them, don't have their youthful libido, and may not feel confident climbing up ladders any more, but they don't want to die... [Our] lives are precious. Don't let anyone tell you otherwise. (McLeod, 2018).

This representation of “older people” by a journalist offers an alternative understanding of what it means to experience old age. The same concepts discussed from Treadwell’s diary (“Diary Reveals”, 2018), memory loss, physical pain, and lack of confidence are expressed, however, the mental and physical decline and social concerns are presented as a ‘normal’ part of the ageing process and, in this portrayal, euthanasia is presented as *unnecessary*.

In summary, in the media discourse of *escape from pain and suffering* power showed itself on bodies by offering euthanasia as a solution to escape physical pain, mental suffering and social concerns. The subjective experience of pain was elevated over medical objectivity and the limits of Medicine's ability to cure all pain was laid bare (Baude, 2014). Euthanasia emerged as symbolic for gaining control of stress and anxiety about the dying process. The idea that suffering could be redemptive<sup>20</sup> was absent in the media. Suffering was mainly associated with social concerns around loss of independence, and was inextricably bound to fear of future suffering, and fear of loss associated with the aging process. The discourse of *escape from pain and suffering* rested on a Western biomedical approach to health and illness and ignored both indigenous and religious perspectives that are holistic and spiritual (Tassell & Lock, 2012). A counter discourse of *unnecessary* challenged the portrayal of euthanasia as a 'good death' and offered palliative care as 'gentle death'. This counter discourse also offered an alternative representation of ageing with age related decline positioned as 'normal'. The next section analyses the subject position that arose from the media discourse of *escape from pain and suffering*.

### **The Subject Position of Getting Out**

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From the discourse of *escape from pain and suffering*, the subject position of *getting out* endorsed euthanasia as a way to take control of the dying process and obliterate pain and suffering. Unlike the *my life my choice* subject position which was highly individualistic in its construction, *getting out* drew upon representations of alleviating the pain and suffering of both the 'self', and others. In this way, it drew on familial governmentality, where the practice of euthanasia was a way in which relationships with loved ones were negotiated and managed.

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<sup>20</sup> Redemptive suffering is a religious concept associated with seeking atonement for sins, and the development of virtue (Cherry, 2018). This is covered more in the subject position analysis.

Witnessing the death of a loved one, preserving dignity and redemptive suffering also mattered to this negotiation.

Occupying the subject position of *getting out* required a belief that euthanasia provided a means to escape the unpleasant and painful processes of dying. A number of readers shared stories related to the dying of loved ones. In the first example below, watching a father “rot” with cancer provided an entry point to this subject position:

Watching my dad rot with cancer was appalling! No way am I going out like that (Kennedy).

While the embodied effects of dying were not spoken of in the media discourses in graphic detail, here, the use of the term “rot” by Kennedy brings to mind ulcerating and fungating wounds. This potential to produce a visceral reaction may have strengthened the desirability of taking up the subject position of *getting out*. The subsequent two quotes similarly refer to first-hand experiences concerning the death of a family member:

I was against any form of euthanasia on mostly hypothetical grounds until my mother died in such pain that she was begging us to kill her (Dylan).

After watching loved ones suffer with cancer that went through the brain, I am all for this bill. It was horrible to watch a loved one suffer (Stevie).

To witness a mother die “in such pain” that a family member was begged to “kill” her and to watch a loved one “suffer with cancer”, produced *getting out* as a way to end pain and suffering of family members, and the suffering of those watching the dying process. In this

subject position, euthanasia is thus viewed as a duty towards ending the pain and suffering of “loved ones”. In the extract below, Riley spoke below of the “horrible end” their mother had, and how this influenced the family in negotiating an aligned view of how to behave in the future if they were “in pain”, or in a “hopeless” condition, and wanted out:

My mother had a horrible end. As a family, we had discussed this possibility and we were of one mind. If any of us were in pain and in a hopeless condition, we wanted OUT (Riley).

*Getting out* relied on the assumption that families would rather die by euthanasia than share in suffering *with* relatives. In this way, enacting euthanasia becomes a duty towards ensuring family members are not subject to witnessing the pain and suffering of the dying person. The idea of being “of one mind” mentioned above by Riley suggests the embodiment of pain and suffering affects all family members in same manner.

Institutions such as health and life insurance are considered mechanisms that manipulate biological features such as mortality rates and accordingly support the emergence of biopower (Foucault, 1975-76 (2003)). How insurances matter to the euthanasia debate and the proposed EOLC Bill is yet to be understood. In the 3-month period of analysis, media was silent on this issue, however, within the subject position of *getting out* the topic of insurance arose as an issue of familial governmentality:

What happens to life insurance with policy holders that pass away via euthanasia (Rawiri).

Make it look like an accident (Gray).

Just a note, great bravado but your life insurance would be void as it is considered suicide (Emery).

Depends on the policy. I've had my policy for many years, so if I committed suicide tomorrow, my kids will be fine (Carson).

In the reader comments, life insurance payouts were discussed at length and the excerpts above examples of this negotiation. *Getting out* relied on considering the financial implications of taking up euthanasia. Interestingly, in these exchanges no sharp distinction was drawn between suicide and euthanasia, with both Emery and Carson referring to a death by euthanasia as suicide. It could be read that in this situation “suicide” is deemed morally permissible, provided your health insurance pays out and your “kids will be fine”.

To be afraid of future incapacity and dependence on others for assistance was uncontested in the subject position of *getting out*:

My life-threatening medical condition will eventually rob me of my ability to walk, dress, toilet or shower myself and will most certainly cut my life short and make my eventual death slow and painful (Morgan).

Not being able to “walk, dress, toilet or shower” seemingly informs Morgan’s motivation for *getting out* along with fear of a “slow and painful” death. A euthanasia death by contrast was rendered quick, painless and dignified as portrayed in the quote below by Drew:

The Bill is not about whether someone dies. It is not even about when they die. It is about HOW they die. Peacefully without pain - or over many days, weeks or months, painfully and without dignity (Drew).

As Drew contended legalising euthanasia is not about controlling death, but ensuring that death is experienced without prolonged pain and loss of dignity. To hold the subject position of *getting out* offered an escape from pain and social losses, such as loss of dignity in the dying process.

While the counter discourse of *unnecessary* put forward an image that symptoms could be managed and a “gentle death” through the practice of palliative care, this notion was rejected in the subject position *getting out*:

Palliative care, no matter how good, cannot always eliminate all pain and suffering. If I reach a point in life where I am suffering pain, I should have the ability to seek competent medical assistance in ending my life (Eli).

What mattered in occupying the subject position of *getting out* was knowing your personal pain and suffering thresholds, thus privileging the subjective experience over medicalisation of the dying process. This thinking is represented in the quote by Eli above who speaks of “reaching a point” where they should be allowed to end their life. That pain and suffering is not linear, has a temporal pattern and can fluctuate was mostly ignored or rebutted:

After going through chronic debilitating pain and coming out the other side, I now have reservations about euthanasia (Glenn).

It's about debilitating pain before death lol you don't get euthanised because you are just in pain (Elliott).

Wrong. Under Seymour's bill "grievous and irremediable pain" counts. His debilitating pain could have been misdiagnosed as irremediable, making him qualify for euthanasia (Maxwell).

In this negotiation, Glenn highlights the temporality of pain, and their comments have the potential to act as a cautionary tale to those contemplating taking up the position of *getting out* on the basis of pain. This position is rejected by Elliott who infers euthanasia is for those already dying, but this understanding is rejected by Maxwell who directs Elliot back to Seymour's EOLC Bill terminology. *Getting out* was thus open to people experiencing prolonged, constant and irremediable pain, but not those with intermittent pain issues.

**Suffering as privilege and redemptive.** In response to Kennedy's statement earlier about watching her father "rot with cancer" Pat resisted the subject position of *getting out*, and portrayed witnessing the death of a family member as a "privilege" for the "insight" gained:

I saw the same. It wasn't appalling for me. I saw my dad as incredibly brave. Certainly, braver than me... He gave me a whole new insight - that I would never have got if he'd been euthanised. Maybe one day my son will have the same privilege (Pat).

This alternative understanding challenged the more common construction of a euthanasia death as a brave and heroic death. Resisting euthanasia also took on a familial

governmentality with Pat commenting that “maybe one day my son will have the same privilege”.

Others resisted the subject position of *getting out* by asserting that suffering could be positive. In the first extract below Nikora shared a view that suffering brings you closer to God and “enables a peaceful death” leaving more “harmonious” relationships and in the second quote Phoenix similarly drew upon a religious discourse:

...people can become free to use this final part of their lives to make their peace- with complicated family relationships, with God, with themselves. Extraordinary healing can take place that enables people to not only die peacefully but leave more harmonious relationships behind in their families (Nikora).

Euthanasia cheapens life. The potential of going through suffering or disability at the end of life is part of the human condition - often it brings you closer to your maker (Phoenix).

As noted, in the *escape from pain and suffering* discourse made available in the media, the notion of redemptive suffering was not present. In the excerpts above we see people negotiating the subject position because of their social and cultural experiences as discourses of *redemptive suffering* and *revivalism* are represented. As mentioned in Chapter 5, *revivalist* discourse refers to practices whereby a patient who is aware they are dying continues to work on themselves to fulfil their life purpose and attend to family relationships (Seale, 2008) such as the practices portrayed in Nikora’s quote. According to Cherry (2018), *redemptive suffering* requires an acceptance of ‘God’s’ control about the timing of life, and provides a source for seeking atonement and repentance. This notion is expressed in Phoenix’s comment that

suffering often “brings you closer to your maker”. However, religious views were cast off as unintelligent, uncaring, and mad:

... she [Mother Theresa] believed that suffering was the only way that poor people could know Christ. In typical Catholic fashion, she was sainted for it. This is why intelligent, caring people dismiss religious based arguments. You're all nutters (Casey).

In the quote above, Casey claimed that suffering was not to be endured. Those who attempted to extol the virtues of suffering were belittled by being called a “nutter”, inferring they were ‘mad’ or ‘insane’. To hold the subject position of *getting out*, there was no place for enduring the suffering associated with religious connotations.

In summary, the discourse of *escape from pain and suffering* provided context through which readers could negotiate and take up the subject position of *getting out*. For those seeking a space to negotiate issues of familial governmentality around duties towards the dying, euthanasia was the answer to escape bestowing pain and suffering on loved ones. Fear of future incapacity and dependence on others appeared to be motivating influences and palliative care was rendered incapable of addressing all pain. As with the other subject positions, those holding religious views were cast off as both irrelevant and irrational; suffering was not to be endured for any reason.

This ends the second part of the thesis where the dominant discourses as presented in the media and their associated subject positions were unpacked and related back to literature. The final part provides a conclusion and commentary on the research process.

## Chapter 7: Conclusion

### Coming to an End

This thesis set out to consider how euthanasia was represented in the Aotearoa New Zealand media and how this mattered to people's thoughts, feelings and practices. In addition to looking at the patterns of text and determining the dominant discourses, three conceptual lenses were applied to analyse the text; neoliberalism, disability and ageing. The dominant discourses of *autonomous right to choose* and *escape from pain and suffering*, functioned collectively to construct euthanasia as a moral and legal 'right' and the preferred 'choice' for the 'autonomous, rational Western individual' who is in physical pain, or fearing future disability or dependency associated with age or illness. In doing so, certain bodies were allowed to die. A terminal condition was not a prerequisite to legitimate euthanasia in the media. Bodies excluded from euthanasia through the dominant discourses were the mentally ill and the religious.

As embodied beings death is so much more than a biological moment, it is imbued with power and meaning. The prevailing discourse of *autonomous right to choose* supported Western cultural ideals and privileged a Western subject. The discourse ignored non-Western understandings of death and dying. Loss of autonomy was produced as something to fear, and this had the effect of 'Othering' those who experience alternative forms of autonomy and those for whom dependency on others is an everyday occurrence. Disability was presented as individualised, rather than a structurally created social phenomenon. Autonomy, rights and choice intertwined to reduce the power of the Church and Medicine in matters of life and death. The moral authority of the Church was challenged and the Church was portrayed as villainous for inducing fear that people were at risk of undue influence and coercion. The power of Medicine was exerted by the exclusion of the 'mentally ill' from the practice of euthanasia which rested on taken-for-granted assumptions suicidal desire for death is irrational, thus

maintaining a separation between sane/rational euthanasia and insane/irrational suicide. The medicalisation of death was opposed from within the medical profession with heroic characterisation of those who supported euthanasia. Stories of predominantly White middle to upper class educated people, and as such produced euthanasia in line with mainstream understandings whereby the practice is taken up by seemingly privileged groups.

Ownership of the body was fought within the subject positions of *my life my choice* and *the defender of rights* where religious and medical anti-euthanasia arguments were disallowed to disrupt the dominant understanding that end of life choices should reside with the self-determined 'individual' as a 'right'. These subject positions allowed for the potential of various feelings and actions to arise including; anger, frustration, braveness, and solidarity with others.

The *escape from pain and suffering* discourse worked to justify euthanasia on the grounds of physical pain. Mental and social suffering also mattered in this discourse, but to a lesser degree. Choosing death by euthanasia rendered a person martyr like. Again, fear of dependence on others was represented in this position. The project of the 'healthy self' was exemplified in the portrayal of Annemarie Treadwell who embodied the spirit of independence participating in self-surveillance activities, measuring her physical and mental health and subsequent decline against healthy and non-disabled norms. Medicine's power to heal physical pain was tested as 'subjective suffering' emerged to be more important in decisions about dying than objective medical knowledge. With some similarity to the 'good death' of ancient times, euthanasia was constructed as a simple, quick and painless death.

Holding the subject position of *getting out* provided the backdrop for expressing responsibilities to family members to ensure pain and suffering was reduced, for both the person who wanted to die by euthanasia and those witnessing the death of loved one. This subject position allowed for feelings of calm, compassion, peace, relief and assuaging of guilt. That suffering could hold any redemptive value was dismissed as irrelevant and irrational.

Counter discourses and resistance arose in the text with euthanasia simultaneously produced as *perilous* and *unnecessary*. Rejecting the discourse of *autonomous right to choose*, euthanasia was portrayed as a dangerous choice for society and in particular for the elderly and disabled communities. Although likely unintentional, the stereotypical portrayal of disability and the classic definitions of vulnerability tied people to particular social categories, which risks reproducing stigma associated with age and disability (Burchardt, 2017). While the dominant construction of ‘autonomy’ was individualistic, the *unnecessary* discourse promoted a medical paternalism that suggested palliative care offered a ‘gentle death’ and should be the appropriate choice in end of life care for people. Neither discourses attended to cultural nuances.

Although the discourses of *autonomous right to choose* and *escape from pain and suffering* are presented in this analysis as distinct, they overlap, intersect and contradict at times. In particular, the neoliberal values of independence and rationality played out in both discourses, marking those who experience dependency and the mentally ill as Other to the ‘healthy norm’. The aged and disabled bodies were similarly portrayed in both discourses as bodies on which euthanasia should be enacted to avoid future loss of autonomy and experiences of pain and suffering. These media messages coalesced with a neoliberal understanding that taking up euthanasia was exercising freedom not to choose such a future. While the *autonomous right to choose* discourse highlighted that decisions should be taken ‘alone’ and free from interference with others, in contrast, the discourse of *escape from pain and suffering* made possible in the subject position of *getting out* considerations of familial governmentality which suggests limits to self-determination in family matters.

Foucault contended power is not held by groups or any one ‘individual’ over another, although it was clear that in the period analysed, the institutions of the Church, Medicine and the State played a role in the euthanasia debate. While traditional anti-euthanasia arguments

from religion such as death under God's control, sanctity-of-life arguments, along with the argument that euthanasia is antithetical with Medicine's role as a healer were not attended to in the media; religious and medical arguments were put forward by readers, reminding us that the media is but one source of influence. The role of the State in exercising biopower was subtly exercised. Legalised euthanasia facilitates the transfer of risk from the State to the 'individual' for making an 'informed decision' about death, one that undoubtedly occurs at a time earlier than a medicalised death, thus lessening the economic risk/burden on the State for providing end of life care. If the EOLC Bill is legalised, the State through the institution of Law will develop procedures that allow for the manipulation of mortality rates.

There was a notable bias in the Aotearoa New Zealand media towards publishing pro-euthanasia articles, and while other research has attributed this to media's liberal inclinations that promote freedom of choice, responsibility and independence (Birenbaum-Carmeli et al., 2006), I contend the increasing secularisation in Aotearoa New Zealand and the reporting of decontextualised opinion polls as social facts (Rose & Osborne, 1999) also informed the media's gatekeeping and agenda setting practices. Adding to a favourable portrayal of euthanasia was the use of elite titles coupled with the heroic rendering of those supporting the practice. The sequencing of anti-euthanasia articles raises some questions about the impartiality of the media in covering issues related to the euthanasia debate. The more extensive articles that expressed opposition to euthanasia were run after the closing date of public submissions to the Justice Select Committee, and in doing so, opposing voices were marginalised. Furthermore, while the media generally claims to hold power to account and reflect diverse communities, diverse views were not sought in equal measure. Surprisingly, the direct voices of older adults were mostly absent in the media which could be read that older adults avoided situations that might expose them as Other. Another possible reading is that they were not invited by the media to discuss their views. As previously mentioned, disabled voices were

represented, but in negative stereotypical ways. The media did not attend to issues raised by the disability community about lack of assistance to choices in life, or concerns around lack of access to culturally appropriate end of life care. By not engaging with non-dominant groups, the construction of euthanasia lacked socio-cultural depth and nuance.

This thesis provides important insights into the construction of euthanasia in the mainstream media as a way to escape pain and suffering under the illusion of ‘autonomous choice’. For critical health psychology, and related disciplines there is a role in making visible the construction of fear and anxiety associated with ageing and disability, and to reflect on the dangerous side of normative standards. Furthermore, rather than affixing the motivation or support for euthanasia on demographic characteristics or traits, it is important to support people as they adjust to the embodied changes that are experienced across the life course, and open up further the conversation that our ‘identities’ are not fixed, but fluid and shaped by external influences such as the media.

### **One Story of Many Possibilities**

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As social constructionists, we are encouraged to take a sceptical stance to any truth claims – including our own, and to ask ourselves, what other ways could there have been of asking the questions, interpreting the findings, and presenting it to the reader (Gergen, 2001). The story told here is a particular story produced by a particular context, one of which relates to the theoretical and conceptual models I applied and the data sources that I unpacked. My choice to review text within the chosen time period produces particular meanings. As such, this story could be read otherwise, and some of the constraints I am aware of are outlined next.

Firstly, I applied a question about what has been previously reported as a Western preoccupation with death and relied on mainstream newspapers, which appeal to mainstream audiences. On reflection, contrasting one mainstream newspaper with a more diverse selection

of newspapers such as *The Spinoff* or the *Asia Pacific News* would have provided for a more nuanced analysis, potentially more counter discourses to unpack, and a richer cultural understanding. I also acknowledge that as a Pākehā, I am a bearer of a dominant, White European culture. To improve cultural appropriateness of future studies on euthanasia and how they might influence Māori, working in collaboration with a person versed in Te Ao Māori, such as a kaumatua would be of great benefit. Secondly, using static data (online news and online comments) meant I was not able to check with the research ‘participant’ if my interpretation was valid and adequately reflected the phenomena under investigated. Nor was there any way of knowing if someone was sincerely engaged in the conversation or trolling<sup>21</sup> the subject. Finally, it was not possible to know the socioeconomic and demographic details of the readers. This may have enriched the analysis particularly in applying the conceptual lenses of aging and disability, although tying people to such categories brings its own risks of homogeneity and ascribing labels of vulnerability.

### **Future Directions**

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The lack of Māori voices in the euthanasia debate has been raised questions whether euthanasia is a Pākehā issue (Rees, 2018). Any practice stemming from media influence that may result in the death of Māori I argue is a Māori issue, and there is a clear gap in the available research. While some say euthanasia has no place in Māori culture (Stephens, 2016), as noted by Malpas et al. (2017a), some Māori practiced a form of euthanasia in the past, but are divided on whether or not it is an appropriate practice today. The importance of wairua, mauri and collective identity are aspects of Māori culture that influence practices around death and dying (Sibley & Houkamau, 2013) and in cultures that value relationships over individualism,

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<sup>21</sup> Trolling is the action of someone who makes controversial comments on internet forums to provoke arguments.

euthanasia has wider family/whānau implications that need addressing (Turia, 2019). Future studies could look at euthanasia in the context of Māori cultural identity and how any future euthanasia legislation can be shaped to take the Māori worldview into consideration.

Age is a common source of discrimination that affects men and women differently, and older women in particular are said to have less or no status in Western society (Ussher, 2010). A Western cultural bias exists that devalues older women's lives and societal expectations of feminine self-sacrifice raise concerns that this group may be more susceptible to euthanasia discourses (Kitzinger, 2015). Without descending into gender essentialism, I undertook a brief review of the euthanasia cases brought to court in Aotearoa New Zealand. In the past twenty years, 100% of the nine euthanasia cases involved the death of a female (Borissenko, 2015). This suggests historically euthanasia has been an issue affecting females. These issues highlight a critical area of research in understanding the role media plays in influencing women's desire to die by euthanasia.

In a debate as polarising as euthanasia and the confusion around euthanasia terminology, understanding how certain terms are taken up by the various pro and anti-euthanasia groups, and how to articulate them in a meaningful way to people living in Aotearoa New Zealand is also important. In order to produce more knowledge about the complex practices of euthanasia, an interdisciplinary team of researchers, from both sides of the debate could collaborate. This could enable more inclusive understanding of end of life options and how they matter to people and communities. The next section provides an update on the End of Life Choice Bill and how this thesis might inform the Bill.

## Update on the End of Life Choice Bill

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Around mid-December 2018, David Seymour made substantive changes to the proposed End of Life Choice Bill in order to garner more political support for the legislation and in response to feedback from the community (Macandrew & Manch, 2018) Proposed changes include limiting euthanasia only to those with a terminal illness, and making it clear euthanasia cannot be accessed on the grounds of disability or mental health conditions only. In the context that terminal illness was not required to justify euthanasia in the media analysis undertaken, this is an interesting shift in direction. Late March 2019, the Justice Select Committee released its report following analysis of more than 38000 submissions. When the report was released the New Zealand Herald<sup>22</sup> informed its readers:

More than 90 per cent of Kiwis who made submissions on the euthanasia bill want the proposed law change scrapped. But backers of the controversial bill say scientific surveys are a better guide on public opinion and have consistently found majority support for euthanasia or assisted dying (Johnston, 2019).

Time will tell the influence of these ‘social facts’ and the various euthanasia discourses as constructed in the media, and how they shape the thoughts, feelings and practices of people living in Aotearoa New Zealand and public policy. A binding referendum is proposed for the next general election.

This research could inform the EOLC Bill by providing valuable insights into how mainstream media shows a pro euthanasia bias, privileges some voices over others, and provides only a partial view of what euthanasia means to those living in Aotearoa New Zealand. These considerations are important as media facilitates and constructs the conditions that make social policy, such as the EOLC Bill possible. Before I close this thesis I critically reflect on

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<sup>22</sup> A similar story was run in Stuff (Manch and Macandrew, 2019).

the research process and how I attended to and acknowledged my social position, personal biases, and power as a researcher. I then offer some final thoughts about how my father's death and the Mosque attack in Ōtautahi Christchurch continue to shape what I know about death and dying.

## Epilogue

### Critical Reflection on the Research Process

I wrote in Chapter Three about how my interest in euthanasia stemmed from reading about Lecretia Seales in the Aotearoa New Zealand press, and finding myself emotionally distraught. Seale (2003) argues that media health stories, and here I include stories about euthanasia, “at some level explore the most fundamental anxiety that we all face as embodied, finite beings” (p. 518). Now I look back at what I knew twelve months ago, I am acutely aware of the lack of understanding I had not only about the complexities surrounding the phenomenon of euthanasia, but also about what it means to have declining health, to age, to be disabled, and other aspects of death and dying that influence decisions about end of life care. As Somerville (2001) argued, few of us have experience of death and dying, therefore in my personal experience, the media was the conduit and a disseminator of knowledge.

Although there was something in Lecretia’s story that resonated with me, I now wonder was it that she symbolised Western privilege? Exploring language and text as I have done in this thesis is a privilege. By applying a critical lens to this research, I understand that euthanasia benefits people like Lecretia, people like me, people like Amy Adam’s mother who had “access to all the care she wanted” (Young, 2018). Most people will not have the time to reflect on the euthanasia debate in detail, and to consider the absent, silent, oppressed and marginalised voices. It is these voices and this conversation that needs to happen.

My socio-political situatedness within Western privilege, in some ways makes me an insider. At the commencement of this thesis, I considered euthanasia a ‘personal’ decision, and my own motivation for wanting to see it legalised was concern about a future where I might need support in daily living activities, in particular I abhorred the idea that someone might have to help me with personal care (toileting). In this way, I was already shaped by the negative

discourses around dependence. Attending to the conceptual lens of disability in my thesis enabled me to see how discourses of dependence and incontinence in particular, create not only a stigmatising condition (Newell 2006), they create fear. I was afraid of a future of dependence which drove my thoughts about legalising euthanasia. This I see now as an influence of normalisation and Western values, that revere the non-disabled body and celebrate independence. My understanding of euthanasia is now shaped by academic research, by the study of 45 news articles, and over 200 reader comments.

Working on a thesis about end of life options was difficult at times because I was also watching the physical and mental health of my father decline and became aware of some deeply held prejudices I had about how our bodies ‘should’ look and our minds behave. This gave me some insight into how norms shape our views, and as difficult as it was, it was also good to unsettle these beliefs. As I move into the future beyond this thesis, I hope to look at others who are shaped differently, and perceive them as a person and not someone who is different – no matter what that difference is. To embrace diversity is to challenge the notions of what is normal, what ‘healthy norms’ entail and to look beyond labels such as race, gender and age that produced the problematic Other, appreciating the unique social and cultural situatedness that each person brings to their various life experiences. The journey with my Dad and his illness was painful. I struggled to be with him as it became more difficult to engage in conversation with him as his ability to communicate deteriorated. Researching one day, I came across the words of Stephen Post who wrote that respect derives from the Latin re-spectare, to ‘re-look’ (Post, as cited in Johnstone, 2016). Post’s words challenged me to look past the label of dementia and influenced me to simply sit and be attentive to my father, withholding any expectations about his physical or mental health. They also influenced me to ‘re-look’ at my own position as I came to realise I had bought in to the rhetoric that healthy ageing meant ageing without physical or mental decline.

My Christian upbringing also affected my engagement at times. I felt aggrieved at what I perceived to be a 'nasty' tone towards those who held religious beliefs. I am also aware that the Church, and the Catholic Church in particular, is rightly under the microscope for its appalling cover ups of past abuse towards children, so in some ways I understand why the power of the Church can be a negative force. With raised awareness of my feelings, I worked to accept the text for what it was, and to come back to the reason for this thesis, that is, to seek some understanding of how power is distributed in social relationships.

If I was terminally ill, in pain, an older adult, or disabled I may have interpreted the data differently. If I did not have a dying father, was without privilege and not religious I may also have interpreted the data in other ways. I may have been angry at a system that was not meeting my needs, or be aware of other social power relationships that mattered to how the media construct practices of euthanasia. If I were from any marginalised group or experiencing vulnerability I would have inevitably presented more insight into voices that are oppressed or silenced and offered possible pathways forward. With the social and cultural positioning I do hold, I know death should not be a social privilege and we must continue to challenge how power shows itself through the media and on the body.

### **My Shifting Views on Euthanasia**

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Around midday on March 18<sup>th</sup> 2019, my father died. In the days leading up to his death, I was brought face to face with the immense power available to medicine in overseeing the passage of death. Before he died, Dad was on an intravenous mix of medications to provide 'comfort'. Only he did not appear to be in comfort. When questioned, he said he was in pain. After some negotiation with Dad's carer and nurse, it was agreed to increase his morphine dose, two hours ahead of the 'proper time'. This was a moment of conflict as I knew that Dad believed only God had the right to control the time of death, yet with medical intervention, there was a slight

possibility that providing additional morphine, the process of death might be sped up. At that moment in time, and seeing a loved one in pain, I supported the notion of euthanasia. In some way, I took up the subject position of *getting out*.

We buried Dad at Ruru Lawn cemetery on the same day 27 of our Muslim community were buried following the March 15 2019 terrorist attack. For a period of time, religion was discussed in the media and we were able to gain some insight into the cultural nuances of death within the Muslim faith. The 51 people that died as a result of the shootings at Al Noor Mosque and Linwood Masjid were represented as *martyrs for Islam*, who in the words of Imam Gamal Fouada had the “best death” possible while dying at prayer (Fouada, 2019). Tensions mounted in our community due to the delayed burials as Islamic death rituals decree burial must occur as soon as possible to free the trapped ‘soul’ from the body. In our ignorance and Western ways, we let our Muslim community down. This highlighted to me how dominant cultural understandings can hurt non-dominant groups in society even after the tragedy of lives lost. I also saw the power of healing as the broader community, and in particular, our Māori community walked alongside their Muslim brothers and sisters in the long journey to recovery.

Death under palliative care, and death by euthanasia are both socially privileged deaths. If it is ‘true’ that euthanasia is mostly taken up by privileged people, I am not sure why we are giving the debate so much attention. As a matter of social justice, we must turn our attention to ensuring all people living in Aotearoa New Zealand have access to culturally appropriate end of life care.

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## Appendices

### **Appendix A. End of Life Choice Bill eligibility criteria**

Eligibility criteria for enacting euthanasia under the EOLC Bill stipulates that a person must be aged 18 or over, be a permanent resident or New Zealand citizen and be in an advanced state of irreversible decline in capability. They must experience unbearable suffering (defined by their personal standard) while having the ability to understand the nature and consequences of assisted dying.

The Bill has clear consultative and advisory directives for any medical practitioner to follow. This includes being aware of other end of life care options, encouraging the person to talk to family, friends, or a counsellor and they must be assessed free from any social pressures. A second and independent medical opinion must support an approved request. Any disagreement regarding a person's competency to ask for assisted death, requires the opinion of a third specialist, namely a psychologist or psychiatrist ("End of Life Choice Bill", 2017).

## **Appendix B. Summary of articles open to reader comments**

The first article was about a submission form made available to Church parishioners that challenged the proposed EOLC Bill and the use of the vague term “irremediable”. It also alleged the EOLC Bill could extend to conditions such as arthritis, gluten intolerance and asthma. This article received 195 reader comments. The second article was an anti-euthanasia opinion piece penned by a National Party MP. It presented broad arguments against euthanasia covering topics such as access to palliative care issues, vulnerability of disabled people to coercion of euthanasia, and conflict with medical ethical issues; it received 59 comments. The next article focused predominantly on public opinion poll results, previous attempts at legislation and Seymour’s external campaign. Some text was reserved for opposition to euthanasia arguments with the Family First leader contending euthanasia was unsafe for society. There were 43 comments. The fourth article conveyed the views of the Disability Commissioner, Paula Tesoriero. It was concerned with the risks to disabled people due to the inclusion of grievous and irremediable (but non-terminal) conditions, and insufficient provisions in the proposed Bill to cover matters such as informed consent, capacity assessments, and how to determine if coercion existed. This article received 186 comments. The penultimate article was about the illegal police check-point that was set up to ‘spy’ on pro-euthanasia meeting attendees, it received 15 comments. The final article covered the views of senior palliative care specialists who were concerned about wrongful deaths due to medical misdiagnosis, the changing mind of patients, and the lack of expertise doctors and nurses had in establishing a readiness to die in patients. It received 76 comments.