



## Dying cancer patients talk about euthanasia

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### A B S T R A C T

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Within developed nations, there is increasing public debate about and apparent endorsement of the appropriateness of euthanasia as an autonomous choice to die in the face of intolerable suffering. Surveys report socio-demographic differences in rates of acceptance of euthanasia, but there is little in-depth analysis of how euthanasia is understood and positioned within the social and moral lives of individuals, particularly those who might be considered suitable candidates—for example, terminally-ill cancer patients. During discussions with 28 such patients in Australia regarding medical decisions at the end of life, euthanasia was raised by 13 patients, with the others specifically asked about it. Twenty-four patients spoke positively of euthanasia, 19 of these voicing some concerns. None identified euthanasia as a currently favoured option. Four were completely against it. Endorsement for euthanasia was in the context of a hypothetical future or for a hypothetical other person, or temporally associated with acute pain. Arguments supporting euthanasia framed the issue as a matter of freedom of choice, as preserving dignity in death, and as curbing intolerable pain and suffering, both of the patient and of those around them. A common analogy featured was that of euthanising a dog. These arguments were typically presented as self-evident justification for euthanasia, construed as an appropriate choice to die, with opposers positioned as morally inferior or ignorant. The difficulties of ensuring 'choice' and the moral connotations of 'choosing to die,' however, worked to problematise the appropriateness of euthanising specific individuals. We recommend further empirical investigation of the moral and social meanings associated with euthanasia.

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### Introduction

Within democratic industrialised nations, discussion regarding medical assistance in attaining death has achieved increasing momentum, beginning in the 1970s and showing no signs of abating (Dowbiggin, 2002). These nations share a number of characteristics: access to sophisticated medical infrastructures, substantial proportions of the populations living beyond 70 years and dying from degenerative or chronic diseases characterised by sustained

periods of medical intervention and a gradual decline in function (Battin, 1991). These democratic nations also take autonomy to be the pre-eminent value in medical practice, asserting the rights and responsibilities of the individual to determine their medical treatment, and to refuse treatment even when this might result in their death (Emanuel, 1998). Simultaneously, individuals expect that the medical profession will ensure a comfortable death (Charmaz, 1980). The combination of these factors has prompted conclusions that the current focus on euthanasia is the logical consequence of cultural assumptions that doctors are obliged to ensure that patients die in circumstances that are acceptable to them (Dowbiggin, 2002).

Euthanasia, however, means different things to different people (Nilstun, Melltorp, & Hermeren, 2000; Parkinson et al., 2005). It is often subcategorised into *active* vs. *passive*

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(which refers to the provision or not of specific medical treatments) and *voluntary* vs. *non-voluntary* vs. *involuntary* (which refers to the degree to which the wishes of the one dying are known and determinative) (Ardelt, 2003). Although a commonly accepted definition refers to 'a doctor intentionally killing a person by the administration of drugs, at that person's voluntary and competent request' (Materstvedt et al., 2003: 98) or *active voluntary euthanasia*, lack of agreement regarding definition has been noted as complicating accurate assessment of the practice of, and support for, euthanasia (Ho, 1998; Nilstun et al., 2000). In addition, 'euthanasia' sometimes includes the provision of pain relief to the point of terminal sedation, otherwise known as the principle of double-effect (Quill, Lo, & Brock, 1997). Critically, although some treat these practices (excluding involuntary euthanasia, deemed homicide) as practically and morally equivalent (e.g., Magnusson, 2002; Quill et al., 1997), others do not (e.g., Materstvedt et al., 2003; Somerville, 2003).

There is a voluminous medical literature debating the pros and cons of either practicing, or legalising, euthanasia (Nilstun et al., 2000). As debate encompasses ethical, medico-technical, legal, and social claims, for and against euthanasia (Ardelt, 2003; Brock, 2000; Sanson et al., 1998; Somerville, 2001), comprehensive coverage is beyond the scope of this article. Dominant arguments for euthanasia center on patient autonomy and well-being (Brock, 2000); those against, on the value of life, and potential impact of euthanasia on medical practice and society as a whole (Hermsen & ten Have, 2002; Sanson et al., 1998).

Although the amount and quality of empirical data lag behind academic debate (Sanson et al., 1998), survey or opinion polls suggest that there is increasing public support for euthanasia. A recent survey of 33 European countries found highest level of support in countries espousing the right to self-determination (Cohen et al., 2006). In the United States, more than two-thirds of the population reportedly favour euthanasia (Duncan & Parmelee, 2006), and in Australia (the site for this study), a poll conducted while the current study was underway suggested that approximately 75% of Australians find euthanasia to be acceptable in some form (Morgan, 2002).

Questions have been raised, however, regarding the validity of survey results assessing euthanasia support, with studies showing variation dependent on the precise wordings and definitions used (Cartwright, Williams, Parker, & Steinberg, 2006; Parkinson et al., 2005). Some writers have observed that opinions that ending suffering is a worthwhile goal and that patient autonomy should be paramount may not equate to support for legalising euthanasia (Cartwright et al., 2006; Johansen, Holen, Kaasa, Loge, & Materstvedt, 2005). Others note that abstracted attitudes may not reflect actual behaviours when faced with a personal choice in the here-and-now (Dowbiggin, 2002; Ho, 1998; Sanson et al., 1998).

Other studies estimate the incidence of euthanasia (again, often plagued by inconsistencies in definition), and correlation studies report on the characteristics of those supporting or requesting euthanasia (e.g., Breitbart et al., 2000). Interestingly, the dominant reason given in support of euthanasia is to avoid intractable pain in the

terminally ill (Emanuel, Fairclough, Daniels, & Clarridge, 1996), yet psycho-social factors appear as important in the decision-making of persons involved (Ardelt, 2003; Suarez-Almazor, Newman, Hanson, & Bruera, 2002).

These findings are echoed by qualitative analyses of interviews with terminally-ill patients, typically concentrating on cancer patients' attitudes towards, or reasons for and against, euthanasia (e.g., Johansen et al., 2005; Kuuppelomaki, 2000). Terminally-ill cancer patients are usually identified as most likely candidates for euthanasia (Kuuppelomaki, 2000) and, where it is legally permissible, most likely to be euthanised (Haverkate et al., 2000; Kissane, Street, & Nitschke, 1998). In a Norwegian study based upon interviews conducted with 18 terminally-ill cancer patients (Johansen et al., 2005), the authors reported that a positive attitude towards euthanasia did not equate to a personal desire to die, and that patients' wishes for euthanasia typically referred to a hypothetical possibility in the future, usually associated with a fear of future, but not current, pain. During an ethnographic study of 30 cases of euthanasia in the Netherlands, Pool (2000) found considerable variation in practice, as decisions emerged in the course of multiple, seemingly idiosyncratic interactions between patients (most with AIDS or cancer), families, doctors, and nurses. There were, moreover, multiple and sometimes contradictory interpretations made by all parties about individual acts of euthanasia, during processes leading up to, and after, the patient's death.

These writers and others have stressed the need to further examine the assumptions underpinning professed attitudes, and the significance of surveys of patient and public opinion (Johansen et al., 2005; Mak, Elwyn, & Finlay, 2003; Pool, 2000). Such calls are echoed by those observing the importance of language in discussions about euthanasia (Pool, 2000; Somerville, 2003).

In a previous study examining how Australian cancer patients (not considered close to death) talked about the decision not to resuscitate following cardiac arrest (the 'do-not-resuscitate' or 'DNR' decision), we observed that many patients mentioned euthanasia. Some equated DNR issues with euthanasia and some considered a lack of hope as legitimate grounds to perform euthanasia (Elliott & Olver, 2003). At the time, events within Australia had brought the euthanasia debate to renewed public attention.

In July 1996, the proclamation of the *Rights of the Terminally Ill Act (RTI Act)* saw the Northern Territory of Australia as the first and only place to allow individuals to access euthanasia lawfully. Nine months later, the Australian Federal Parliament amended the legislative powers of the Australian Territories (*Euthanasia Laws Act*, 1997), prohibiting legislation on euthanasia, thus overturning the *RTI Act*. During its operation, there was extensive media coverage regarding five of the seven people who applied to die under its terms, four achieving their aims (see McInerney, 2006; Street & Kissane, 2001, for analysis of Australian media accounts). Despite the repeal of the *RTI Act*, euthanasia legislation has been proposed since in various Australian states, without success (Kerridge, Lowe, & McPhee, 2005): euthanasia remains illegal.

During the present study, there was considerable media coverage regarding Nancy Crick who, following her

apparently unsuccessful surgery for bowel cancer and subsequent unremitting pain, very publicly asserted her right to euthanasia (Crick, 2002). After her suicide in the presence of 21 others, national and international media debate focused upon the significance of autopsy results revealing no presence of cancer. Although reporting that those endorsing Nancy's actions held that her avowed suffering rather than her diagnosis was the critical factor that legitimised her claim to euthanasia, media stories tended to focus on a claimed discrediting of the pro-euthanasia lobby (e.g., see Goodenough, 2002; Kelly, 2002).

Considering these public events in conjunction with the findings in our earlier study we believed that further exploration of how patients talked about euthanasia and of the meanings associated with it, was warranted. Accordingly, in the present study examining how dying cancer patients talked about making medical decisions at the end of their lives (primarily focusing on the DNR decision), we included within our interview protocol a question on euthanasia.

## Method

### Participants

This study was approved by the hospital ethics committee. Patients from the hospital palliative and oncology clinics meeting selection criteria were asked to participate in an interview about making treatment decisions at the end of life. Selection criteria were that patients were older than 18 years with English as their first-language, were deemed capable of coherent discussion, and emotionally stable. Twenty-eight patients provided signed informed consent to be interviewed (see Table 1 for disease and demographic details of participants). Their primary cancer sites varied, but all were in the final phase of their illness, and aware of their prognosis of approximately 3 months to live: Most (82%) died within that time. All but four participants were currently admitted as in-patients. Twenty-one patients were interviewed in their hospital bed, and the others in a consulting room. Fourteen chose to have a friend or family present, some of whom occasionally spoke.

### Interviews

Interviews were conducted by a social scientist (JE), an experienced interviewer with no prior or subsequent relationship with patients. Interviews were audio-taped and transcribed verbatim, with text then entered into N6 software (Qualitative Solutions and Research, 2002) to facilitate analysis. Recruitment ceased when subsequent interviews raised no further substantive issues. Pseudonyms have been adopted.

Although the interviews began with discussing the DNR decision (see Olver & Elliott, 2008, for interview questions on DNR decisions), 13 persons spontaneously raised the issue of a patient's life being deliberately shortened by a medical professional. When this occurred, JE confirmed that they were talking about euthanasia, and encouraged further discussion (e.g., 'So what you're talking about is euthanasia?' and/or 'Can you tell me more about that?'). Patients who did not raise euthanasia during comprehensive

**Table 1**

Demographic and disease-related details of dying cancer patients interviewed

Details	Number
Site of primary cancer	
Colorectal	6
Lungs	6
Breast	3
Lymph	3
Renal	3
Other	7
Age	
Mean (SD)	61.4 (12.8)
Range	39–79
Sex	
Male	15
Female	13
Partner status	
Married/partnered	18
Single	3
Divorced	4
Widowed	3
Highest education level	
Primary	7
Secondary	12
Tertiary	7
Unknown	2
Religion	
Christian	19
Druid	1
Unknown	8

discussions about the DNR decision were invited to talk about euthanasia (e.g., 'Some people have mentioned euthanasia, can you talk to me about that?'). We did not define euthanasia as we were interested in patients' understandings, independent of prompting by us. We considered that, at this point in the interview, patients were likely to be comfortable with discussing life-and-death issues, and unlikely to be disturbed by the introduction of euthanasia for discussion. Nonetheless, some did not wish to discuss euthanasia extensively and others appeared fatigued. In these instances, respect for patient well-being dictated that discussions were relatively short. Thus, the amount of talk on euthanasia varied from approximately 200 to 2000 words. Finally, to ensure that euthanasia was not the final subject discussed, patients were subsequently asked to talk about Complementary and Alternative Medicines (Elliott, Kealey, & Olver, 2008), hope (article under review), and anything else they considered relevant.

The physical and emotional well-being of patients was paramount. Patients were assured that counselling was available if they became distressed or had issues needing resolution as a consequence of participation. Some patients cried during the interview. We considered this understandable given the subject matter and patients' circumstances, providing silence, comfort, and tissues where appropriate. No patient became overwhelmingly distraught. In two cases when the interviewer moved to terminate an interview in response to overt distress, patients indicated their desire to continue, with the distress resolved as conversation progressed. No patients requested counselling

following participation in the interviews. Several reported the experience to be valuable and enjoyable, and three patients requested and received a transcript of their interview, considering it a legacy to their families, recording their thoughts on important issues in their final days.

### Analysis

Our theoretical perspective is social constructionist, with analysis resting upon two assumptions: (1) In using language, individual speakers draw upon pre-existing ways of talking about things, patterns of meanings or 'discourses' that are culturally and historically specific. Within a culture, there may be many discourses, but some may be culturally dominant, taken-for-granted, and thus be more readily invoked. In drawing upon available discourses, speakers reproduce and collectively reconstruct (rather than just describe) their social world. (2) Talk is action-oriented, as people use language to do different things. Thus, individual accounts of a phenomenon will vary dependent on the context within which the accounts are produced (Potter & Wetherell, 1987).

Our focus was on how dying cancer patients talked about euthanasia, on the language used to justify a position taken, and on wider social implications of their talk. Specifically, we were interested in how individuals constructed and negotiated meanings around euthanasia, what wider systems of meanings (or 'discourses') were drawn upon in their talk, and how self and others were positioned within their speech (Davies & Harré, 1990). Accordingly, we employed a 'synthetic' approach to discourse analysis (Wetherell, 1998). We began by coding the data into categories representing particular ways of talking about euthanasia, with further analysis attending to the local interactional context of talk, and considering wider societal ideological practices. We reviewed and discussed provisional conclusions with health-care workers and qualitative researchers, and present data and analysis together to facilitate reader assessment of the credibility of our analysis.

The transcription protocol is as follows for the following excerpts: [ ] indicates clarification of meaning; = indicates abutting or overlapping speech; () indicates paralinguistic sounds, e.g., crying; ... indicates words omitted for ease of reading; (...) indicates inaudible speech.

### Data and analysis

To summarise, 24 patients spoke positively about euthanasia at some time during the interview, with the predominant discourse centering on personal choice, usually augmented with notions of compassionate ending of suffering. These patients, however, typically talked in terms of a hypothetical future or of some hypothetical other. Nineteen patients raised concerns at some point. Some spoke of the difficulties around defining and achieving choice, some made an actual or potential association with murder or suicide, with many inferring moral judgements that might be made about involved parties. Four were completely opposed: Two deemed euthanasia interference with God's will, one equated it with murder, and the other

curtailed discussion, describing the topic as something he 'didn't believe in.'

### Positive talk

The following excerpt exemplifies the most common discourse drawn upon to sanction euthanasia, namely, the rights of the individual to choose and not to be dictated to by others.

*Yves.* I think it's a person's ... free choice to do what they do, not to have someone tell them that they can't do what they want to do. ... It should be up to a person, if they want to do it.

Others have reported that patient assent to euthanasia appears to be a necessary and prioritised variable in determining its appropriateness (Ho, 1998). Although not unexpected given the value placed upon individualism and autonomous action within the Australian healthcare system and society in general (Leeder & Lewis, 2001), it is worth exploring some consequences of the autonomy discourse in this context.

Framed in these terms, euthanasia is presented as no different from any other act that an individual might choose. This strategy not only works to normalise a potentially controversial procedure of procuring death, but implicitly to position those opposing euthanasia as curtailing individual freedom of choice, an untenable position in Australia, and other democratic liberal nations. Furthermore, talk of rights thwarted tends to be confrontational (Donchin, 2000), working to establish dichotomous and mutually exclusive camps, here opposers and supporters of euthanasia.

Indeed, a defining feature of arguments favouring euthanasia was the positioning of those who opposed it as fundamentally and wilfully opposed to freedom of choice. Following this positioning, one patient characterised opposers as either ignorant or morally inferior.

*Xavier.* Euthanasia is only a matter of choice after all, and the people that are trying to deny it are those who don't want others to have choice ... I can't direct them, why should they direct me? That's what they're trying to do. Sometimes it's religious-based of course, and there's nothing more narrow than someone who's narrowly programmed. Some people are narrowly programmed, they're like a computer, they'll keep repeating the same stuff, ... and then the politicians are often influenced by small minority groups because small minority groups can swing marginal votes, and so it's not the majority that's talking, it's the minority.

All the listed characterisations deviate from the model of the individual (including the patient) as the rational, independent, socially responsible individual prized within western culture (Janis, 1984). Their employment thus functions rhetorically to marginalise the acceptability of voicing opposition, simultaneously explicitly or implicitly positioning those favouring euthanasia as the enlightened, the compassionate, and the majority.

By establishing individual rights as the terrain upon which euthanasia debate is centered, this ontological

gerrymandering (see [Potter, 1996](#): 183–7) functions to minimise the opportunity or possibility for individuals to profess rather more nuanced positions, and to preclude meaningful dialogue between ‘opposing’ camps. The focus on individual autonomy also works to obscure that euthanasia requires not only an individual’s request to be killed, but another’s assent to kill them. The pre-eminence of the autonomy discourse thus works to conceal the social and moral implications of euthanasia.

For the most part, autonomy was a necessary, but not sufficient argument for euthanasia. A common qualifier raised was that of pain, typically described in extreme terms.

*Yves.* I think that if a person is going through astronomical pain and discomfort, anything like that, and they want to die, I think they should be allowed to go, rather than being put off.

*Vera.* I think where it gets to where ... their medication can’t ease the suffering, and it’s obviously something terminal, then I think yes, euthanasia is available.

Desiring euthanasia is here construed as an appropriate, understandable response to pain by the patient. Its provision is simultaneously identified as the appropriate, compassionate response by the observer, and euthanasia thereby favourably positioned. The legitimacy of this position is further strengthened through the descriptors employed, using extreme-case formulations ([Pomerantz, 1986](#)): Because pain is astronomical and suffering intractable, opposing euthanasia is implicitly negatively positioned as inhumane.

Nominating pain as a qualifying condition also works to limit the potential candidates for euthanasia, as does the restriction to cases of intractable suffering when terminally ill, providing a counter-point to assertions of autonomy as the pre-eminent value. Although suffering that might be addressed by medication implies a focus on pain (locating euthanasia within a bio-medical discourse) a further argument raised was that of dignity (a social and moral issue extraneous to the bio-medical discourse).

*Tina.* [W]hen Auntie Nell went ... , she always wanted to die with dignity, and she was just a little bag of bones lying in a bed, and you’d go to pick her up, and all of sudden, all I’ve got is a bag of skin on my hands. No, it was horrible ... . Well, she wanted to be put to sleep, ‘cos she wanted that euthanasia.

Through employment of vivid extreme descriptors, dying and associated biological changes were consistently presented as inherently distasteful and undignified. Dignity is thus taken to be incompatible with a dying body. This reflects and re-affirms the importance placed within Australian culture upon maintaining a well-controlled and physically attractive (or at least not physically repulsive) body ([Street & Kissane, 2001](#)). An emphasis on an obedient presentable body is also evident within Australian media accounts of euthanasia ([McInerney, 2006](#)). The inference here is that it is better to be dead than to exist when this is no longer attainable.

The dignity argument also encompassed more than just the person dying, incorporating the reactions of those

observing to associated physical changes. This suggests that, while requiring a complaint body, dignity resides in more than just that body, being additionally within the socialised reactions of those observing (including the patient), again locating euthanasia within a social domain. Indeed, a common argument given in support of euthanasia was the negative effect of the dying process upon others, often presented as a self-sufficient argument that this process should be as expedient as possible.

*Xavier.* Oh absolutely, absolutely [I’m in favour of euthanasia], not just for yourself but for those around you, ... watching people go through it is much worse, in some ways than the person, because the person can be ... zonked out, but I think that’s not very dignified anyway, but, but the others have to watch. And they’ve got no anaesthetics (laughing) or anything to get them through. And they’ve just gotta suffer, it disrupts their lives, it disrupts their mental processes, it’s very unsettling for them.

This frames a request for death in a positive light, widening the scope of persons who might benefit from it and positively positioning supporters (including the patient) as altruistic, as responsibly and compassionately considering the welfare of others. Critically, the shift from an individualistic focus to a social and communal one—again, inviting a compassionate response—further strengthens the argument for euthanasia. Again, however, it presumes the dying process to be inherently distasteful and disruptive ([McInerney, 2006](#)), dismissing possibilities that witnessing death might have some benefit ([Ardelt, 2003](#)), or that families might rather suffer with, than without, their relative. It further presumes that any suffering involved in the death of a loved one will cease once the patient is euthanised; that euthanasia is easily attained; and that it produces no suffering. Some writers have suggested that these are problematic assumptions, claiming that family distress over their involvement in decisions about the manner of a patient’s death is likely to be exacerbated in the event of a planned death ([Donchin, 2000](#)), particularly where all does not go as planned ([Nuland, 2000](#)). Investigations into medical attempts to bring about death have shown that these attempts sometimes go awry ([Groenewoud et al., 2000](#); [Pool, 2000](#); [Starks et al., 2007](#)), and that family experience distress before and after decisions to end a patient’s life are made and realised, particularly when death does not occur as anticipated ([Pool, 2000](#); [Starks et al., 2007](#)).

Ultimately, participants’ use of vivid and extreme language to depict the dying process as inherently distasteful, invariably painful, and resulting in extended suffering for all involved, implicitly positions those opposing euthanasia negatively as limiting attempts to curtail these undesirable states. Sometimes such accounts of the dying process were employed explicitly to position people opposing euthanasia negatively, who were described in derogatory and pejorative terms.

*Kate.* And these do-gooders who (...), ... obviously haven’t had to watch somebody suffer so, that sort of agonising death.

*Nina.* Some of these dear old souls [who want to be euthanised], ... you can see that they are not long for this world, and they must be going through untold misery, I cannot see why they should have to go through all this misery, just to satisfy some higher bigwig that think [sic] they can make money out of other things, no, no, it's not, I don't think it's right.

The term 'do-gooder' works to construe those opposing euthanasia as well-intentioned but naïve, and ultimately as less than credible; 'bigwig' connotes a nameless person in power, here exercising this to their own interest in callous disregard for the well-being of deserving and vulnerable others. Using these terms in this context works to ridicule and disparage those opposing euthanasia, and to dismiss the possibility that opposition might stem from anything but nefarious or ill-informed sources; further, to position the euthanasia opposer as distant from, and lacking empathy to, the vulnerable dying patient, with the implication that individuals more aware of or sensitive to the realities of the dying process would support euthanasia.

#### *The 'dog' analogy*

The most common analogy featured was 'You wouldn't do it to a dog, you'd have it put down'.

*Vera.* I mean, we're kind and we put animals down, ... but when it comes to human-beings who are suffering dramatically ... , I just think it's terrible (...), it's cruel. We wouldn't do it to our pet dog ... .

This analogy is often drawn upon in support of euthanasia (Bachelard, 2002). To the extent that 'You wouldn't do it to a dog' is common parlance, it functions rhetorically to end discussion, appearing to require no further debate (Drew & Holt, in Potter, 1996: 168). In equating humans and dogs, it construes humans in terms of biology, legitimising medical intervention. It places responsibility for euthanasia, indeed, for the ongoing negative experience of the dehumanised sufferer, onto the viewer, negatively positioning them if they do not compassionately and responsibly take action to end this life of pain and suffering. Much of the language used here reflects the agency of the euthaniser or those directing them, and passivity of the euthanisee, who is to be 'put down,' which seems antithetical to the dominant discourse of patient autonomy. In this context, however, the focus on pain and on humans' biological similarities to dogs works to legitimise, even demand, action on the part of the observer.

This analogy is rhetorically appealing and difficult to refute, and it works to obscure ways in which humans are not like dogs, both in relation to pain and their relationships with others: Humans can articulate their pain, can request pain relief, and possess the capacity to value and find meaning in being alive and relating with others while enduring pain (Bachelard, 2002). In construing humans in biological terms, the 'dog' analogy marginalises moral and social considerations that might work to challenge the appeal and appropriateness of euthanasia. For example, unlike dogs, humans are not owned by others to the extent that others can decide their fate unilaterally, and to treat

persons like dogs is generally considered morally repugnant and unjustifiable (Bachelard, 2002). We contend that this analogy can only work through its focus on pain and construal of the patient as other, as helpless and dehumanised. It is essentially an 'outsider' discourse, relying on both the speaker's and hearer's implicit positioning of themselves as the observer who compassionately takes action to end the suffering of a helpless other. The voice of the patient is notably absent, indeed, is rendered mute, and their capacity to direct events is negated—conditions which are normatively unacceptable within Australian society, particularly in a medical setting. In the sole example of speech wherein a patient positioned themselves as the sufferer, he specifically rejected any similarity to dogs.

*Oliver.* [ I ] got to the end of my tether like. ... I wouldn't let my dog go through it, or any animal that I had control of, I wouldn't want them to suffer that pain, I'd sooner just rest asleep in peace, rather than going through that. But I'm not a dog, I'm a human-being. And I don't really want to leave (crying) this. Leave this human race that I'm a part of, I, I don't really want to leave it (...), so (crying).

Oliver initially reproduced the dog analogy in its most characteristic form, taking a third-person perspective which readily works to legitimise euthanasia. When switching to a first-person perspective, however, the resulting implicit positioning of him as a dog subject to the 'control' of others became untenable, indeed distressing. In rejecting this, he explicitly defined himself in ways that differentiate humans from dogs, stressing the existence and value of his awareness of his mortality and social connections. This example, we suggest, indicates that support for euthanasia predicated upon the dog analogy may rely on creating and maintaining distinction and distance between those acting and those acted upon, between the speaker (the owner) and the patient (the dog), between self and other. At least in this instance, the dog analogy plays out differently when considered personally, as humans typically do not want to be categorised or treated as dogs.

#### *Negative talk*

Although most patients spoke favourably of euthanasia, many envisaged difficulties with it as practice, specifically, of ensuring that it was not abused.

*Vera.* If only they could surround it in correct procedures, ... I thoroughly agree with it. ... [B]ut I don't know how you'd hold it within its boundaries. ... But it's the other complications, ... it being abused by professionals and people and, yes, and people are not all good holy souls (laughter).

The language used here suggests an entity predisposed to mutating beyond control, needing constant procedural and bureaucratic boundaries. These may not operate to empower dying patients, but to increase their engagement with physicians assenting to and providing euthanasia, and the gatekeepers held responsible for policing practice (Pool, 2000).

Patients' concerns also work to problematise the motivations of persons involved in practicing euthanasia, implying that medically assisting others into death might not be confined to those requesting it, but be extended to others meeting criteria already established as justifying euthanasia. Indeed, Pete's opposition to euthanasia was associated with his concerns that euthanasia might include some unnamed 'them' determining his suitability to be 'popped off.'

*Pete.* I don't believe in euthanasia. ... I don't want them to get to the stage of saying, 'look, you've gone downhill, you're going to be in bed for the next six weeks, and you could die. We're going to pop you off now.' No. That's all bull-dung.

Although technically referencing homicide, Pete did not differentiate this from euthanasia. This understanding is not confined to these participants as some medical writers include homicide within the category euthanasia, terming it involuntary euthanasia (Magnusson, 2002). Other participants drew similar parallels.

*Opal.* [Euthanasia] could be a very convenient way of getting rid of people if they wanted to couldn't it? (laughing)

*Wendy.* So, people can use it for their own resources ... [Someone might see it as that poor retarded kid's got no quality of life, and therefore assist in euthanasia.

In part, concerns about involuntary euthanasia, articulating the 'slippery slope' argument often cited when opposing euthanasia (Ardelt, 2003), may arise because these discussions often featured the same discourses used to justify the more accepted version, quality of life, or compassion, for example. Similarly, we have noted elsewhere that two of these patients consistently confused the term DNR with the practice of euthanasia (Olver & Elliott, 2008), and that the discourses used to justify the former are readily transferable to the latter (Elliott & Olver, 2007). This may work to construe euthanasia as merely an extension of normal practice, therefore as uncontroversial. Regardless, the variation in what participants associated with euthanasia confirms the difficulty of assessing public opinion. It also suggests that potentially different moral judgements might attach to individual acts, with different motivations potentially attributed to those involved.

Those identified as involved in euthanasia, moreover, may extend beyond those immediately present and active, to include medical professionals who, it may be held, should be involved, and the wider community who, aware of the situation, have opinions about it. This was evident in Zack's account of the highly publicised death of Nancy Crick.

*Zack.* Oh, what I think about euthanasia is ... they should all have a proper medical check and I mean a thorough one by independent doctors, if they're gonna say that they're in pain. ... The thing that really got me was this one [Nancy Crick] that died recently, why didn't the AMA [Australian Medical Association] and all the rest go through her case-notes to make sure that she was actually in pain? You see I think she just tricked the world.

... I'd rather have people check to make sure that they're not lying and that they're in remission, ... [not just] 'I'm in so much pain' and all that, you know. ... I'd like to see ... a psychiatric report done on her [Nancy Crick] I reckon. Yeah, I think, just so everyone else knows in Australia what it's, why they all got duped about it.

Of relevance here are how Nancy Crick's death is understood (specifically, as pertinent to the euthanasia debate), who is identified as involved, and the meanings attributed by Zack to persons and events. No-one emerges unscathed. In asserting a right to euthanasia on the basis of her unremitting pain, Nancy is explicitly identified as lying, as tricking the world. The justificatory capacity of subjective pain and patient autonomy are thus thrown into question, in contrast to assumptions made elsewhere. The implicit contrast with her treating doctors and some 'independent doctors' (who might have performed some 'proper medical check') works to negatively position the former as having some vested interests which presumably hindered their accurate assessment of Nancy's pain. Further, the nomination of the authoritative medical board in Australia, 'the AMA' and 'all the rest' positions the entire Australian medical community as culpable, as remiss in not intervening to oversee the case and determine the truth, judging the veracity of the patient and the competence of the treating doctors. Finally, the entire Australian nation and 'the world' are deemed to have been 'duped,' presumably because they took Nancy's claim of unremitting pain as legitimate, and as compelling grounds for euthanasia.

The language used in Zack's account (e.g., 'The thing that really got me was ... she tricked the world') suggests a sense of betrayal, through a series of moral inferences that work to identify acts of intentional death as significant moral and social events. Throughout, doctors' authority to confirm or deny patients' assertions of pain, thus to veto euthanasia, is presented as desirable, even indispensable. The rights of the patient to determine their pain and to claim euthanasia—the legitimacy of patients' voice and patient autonomy—are thus nullified or dismissed. Finally, and notwithstanding Nancy's explicit accounts of her own motivations, her actions are interpreted as, at worst, duplicitous, and at best, driven by some psychological deficit that might be discerned by appropriate psychiatric examination.

Other talk suggested that negative moral judgements might be made regarding those requesting euthanasia—that they were depressed, or lacking a strong will to live, taking an easy way out, or acting precipitously, perhaps.

*Ross.* I've never believed in it. But I've always understood how people in severe pain perhaps with depression or whatever would want to go down that track. Yeah. ... No. No, I've always had a strong will to live.

*Kate.* [O]f course with sort of euthanasia and all that and maybe, some people want to take the easy way out, and in some cases they might find that their illness would have, sort of fixed itself up anyway.

Although the proposed characteristics of the euthanasee work to render their actions intelligible, they

simultaneously constitute them as of lesser moral status (Barnes, 2000). The potential invocation of moral judgments was also evident in talk that linked euthanasia and suicide.

*Vera.* No. No. I might later on, you know, in the future I've got no idea how I'll, you know, but not at this stage, no. At this stage I would be bit of, taking the suicide [option] (laughter). Because it's not necessary, so no.

Unlike the positive assessments of euthanasia as enacting the responsible and rational, adult, suicide is typically negatively evaluated as indicating psychological or moral impairment (Bennett, Coggan, & Adams, 2003). As the difference between euthanasia and suicide appeared predicated upon a subjective determination of an appropriate stage, again, questions may be raised regarding the moral and psychological status of those involved. Assumptions that euthanasia is, or will be interpreted as, simply a matter of choice appear somewhat simplistic in the light of these data.

Two patients unequivocally opposed to euthanasia did not identify death as an issue over which individuals could legitimately exercise choice. Rather, they construed euthanasia as an inappropriate usurpation of God's authority to determine the manner and moment of death, possibly with consequences lasting beyond this life.

*Sally.* So I do not believe in euthanasia, ... I think it's God's will ... that we don't interfere with that type of thing. Death is death to Him. And He will take us when the right time comes, when He has that mansion in the sky (...).

Though an uncommon discourse in this population, participants were exclusively Anglo-Australian. Arguments presupposing the interest of a divine authority in the manner of our death may be more commonly espoused by persons who identify with other cultural and religious practices (Sanson et al., 1998). In such cases, euthanasia might be deemed sacrilegious and heretical, again indicating the need to consider social and moral aspects of euthanasia, in practice and policy.

#### *Time-linked talk*

As noted earlier, a typical feature of patients' talk supporting euthanasia was their reference to the plight of some hypothetical other. Where patients engaged personally with the decision, stating their own wishes, this took the form of an endorsement for a future hypothetical 'right time', some explicitly stating that this was not now.

*Kate.* Well you know, I'd be there, I'd be there for it if, if it was, the, the right time. ... [T]hat's a whole can of worms that I'd think I'd rather keep the lid on at the moment. Because (laughs) I don't think I'm in that position myself.

This demurral may be because euthanasia is illegal in Australia, but these examples support claims that a patient's endorsement of euthanasia in an abstracted future need not equate to a desire to be euthanised in the tangible present (Dowbiggin, 2002; Johansen et al., 2005). It could also

be noted that the 'right time' may never eventuate (Mishara, 1999).

A personal endorsement for euthanasia also featured in accounts that suggest that a wish to die was a response to extreme, ill-controlled pain.

*Tom.* [W]hen I was admitted back here to hospital that the agony and the pain, the trauma, that, not only me, but that we [Tom and his wife] were both going through. ... I would have selected the do-away needle or something like that you know. ...

*Interviewer.* What do you think about euthanasia=

*Tom.* =No, I don't altogether agree with it, you know. But I haven't really thought about it, and I wouldn't like to talk too much on that you know.

Although anticipated pain has been associated with favourable attitudes to euthanasia in a hypothetical scenario (Johansen et al., 2005), here patients' immediate wish for death appeared temporally confined to an immediate experience of pain. Once pain was medically controlled, patients rescinded such wishes, with no patients suggesting during interview that they wanted to be euthanised now, or even soon. The language used by Kate and Tom works to distance them in the present moment from any endorsement of euthanasia, and to limit further conversation, precluding attempts to determine an 'actual' view. Collectively, this reveals a complexity that is masked through simplistic attempts to gauge abstracted attitudes.

Pain also featured in the accounts of two other patients, one of whom asked to be killed, and the other who attempted to kill himself. Neither patient acted to procure death once their pain was under control, and neither involved medical persons nor procedures.

*Paul.* I'd find it very difficult to do it myself, or give the nod to somebody, sort of like 'do it now'. When I was drunk, I tried it a couple of times. Should have worked. But it didn't, it didn't. Couldn't do it sober, and I don't want to do it drunk. ... Because there's a couple of occasions I have been in agony. Mouth full of paracetamol, brandy, and I would [be] punching the wall to make myself hurt somewhere else. At a time like that, I could understand it certainly.

In accounting for his attempt to kill himself, Paul legitimates this as an understandable response to pain, while distancing his current self from the earlier self. He simultaneously characterises the former self as beyond rational control (both drunk and driven by pain) and the intent to procure death as something that the more rational self (now sober and not in pain) cannot endorse. This account works to construe a request for euthanasia and the potential euthanasia as driven by irrational forces, challenging the version that favourably presents euthanasia as an enactment of free choice.

#### **Conclusion**

Participants in this study were exclusively Anglo-Australian and predominantly Christian. As views on euthanasia are known to vary across nations and different ethnic groups (Cohen et al., 2006; Sanson et al., 1998),

this may limit the degree to which our analysis applies elsewhere. Our current research program includes interviews with similar patients within a different cultural setting. Only dying cancer patients were interviewed, and patients dying from other illnesses may draw upon different discourses when considering euthanasia. Discourses drawn upon in arguments for or against euthanasia, however, were not specifically associated with cancer, and may have currency for patients with other diagnoses. Patients' talk on euthanasia happened in the context of an interview with a primary focus on the DNR decision, and often towards the end of that interview. Consequently, discussions about euthanasia were not as far-ranging and as in-depth as they might have been if euthanasia had been the primary focus of the interview. A strength of this approach is that patients were less likely to be confined to those who had and were willing to offer pre-determined strongly-held views on euthanasia.

We analysed how dying cancer patients talked about euthanasia, considering variation in the language used to support and to problematise the practice. Based on this analysis, we argue that defining euthanasia in terms of *your* personal choice and *my* compassionate response to your physical suffering (respectively, invoking discourses of individual autonomy and compassion), is overly simplistic. While patients routinely and readily re-presented these discourses, other aspects of their talk worked to undercut them. Patient support for euthanasia was typically in the context of a hypothetical other or in some hypothetical future, and sometimes as a personal request temporally associated with extreme pain. Participants appeared to assume that euthanasia would be easily attainable as an enactment of personal choice, even while they argued for rigorous guidelines that would operate to problematise the exercise of choice. They also appeared to assume that it would uncomplicatedly relieve suffering through guaranteed production of death, neither producing nor resulting in suffering for anyone involved in the process, assumptions that previous research has identified as problematic. Furthermore, sometimes patients' speech demonstrated negative social and moral judgements about those involved, whether involvement was through direct physical engagement or through indirect reflective observation.

We noted discursive features of arguments for euthanasia, including the use of hypothetical scenarios, reliance on an outsider discourse, and negative characterisation of those opposing euthanasia. Finally, we observed that the structure of argumentation around choice and pain worked to create mutually opposing camps with opposers characterised in highly negative terms. We suggest that this works to marginalise the acceptability of voicing opposition to euthanasia.

Ultimately, what was absent from patients' talk on euthanasia was consideration of any negative effect, whether this be upon those involved in decision-making, those practicing euthanasia, those witnessing, those left behind, or upon society as a whole that chooses to tacitly accept the conditional judgements surrounding euthanasia. When discussing the DNR decision these patients tempered the dominant discourse of individualistic autonomy with notions of relational autonomy, identifying

personal choice as appropriately constrained by moral and social reciprocity between individuals, considering familial, structural, and societal-based relationships (Elliott & Olver, 2007). Such concerns were completely absent when discussing euthanasia. These concerns may have featured in an interview devoted to euthanasia, but the dominance of the discourses of individualistic autonomy and compassion in the wider euthanasia debate (Ardelt, 2003; Somerville, 2001) may work to limit the ways in which individuals conceptualise and frame issues around euthanasia.

Survey studies showing majority support for euthanasia have typically required individuals to make judgements about hypothetical and abstracted scenarios. Under such conditions, individuals are likely to draw upon the readily available and socially approved discourses of autonomy and compassion, and voice approval. To conclude that this legitimises euthanasia as social policy is to deny the import of other factors that feature when individuals have opportunity to do more than endorse or reject euthanasia. More empirical investigation is required, and we recommend elicitation and analysis of patients' talk addressing the social and moral consequences of the act of euthanasia (in practice and in legislation). Optimally, analyses should include the views of family members potentially affected by euthanasia, as well as those who might be called upon to euthanise.

Finally, we suggest that those interested in euthanasia as a social practice should aim to widen public debate beyond the parameters of individualistic autonomy and compassion, attending to the moral and social aspects of medically and deliberately inducing death in a consenting individual. This is not an easy task, requiring that we, collectively and individually, interrogate highly valorised notions of self, control, death, and medical jurisdiction. Only then, however, can we have a well-balanced discussion that might enable us to make well-informed decisions that incorporate the social and moral consequences of euthanasia.

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