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Discursive Perspectives on Assisted Dying

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1. Introduction

'Assisted dying' broadly refers to 'the intentional and voluntary ending of life of a competent person either by their own hand, medical person, or nominated other' (Booth and Blake 2022: 108). This chapter explores contemporary language use around assisted dying, focusing on how people and institutions use discourse to define assisted dying, to debate it, to represent it and ultimately to practice it. Assisted dying is controversial and its legal status varies between countries. As we will see, public discourses surrounding the topic exhibit similar variability, ranging from those which view it as a human right to those which view it as immoral and equate it with murder.

Following this short introduction, the second section presents the topic of assisted dying in more detail, before the third section reviews linguistic and discourse-oriented research into communication surrounding assisted dying across a wide range of contexts. In the fourth section we present, as a case study, a discourse analysis of parliamentary debate about assisted dying in the United Kingdom (UK). A qualitative discourse analysis is presented, drawing on examples from a corpus of almost 40,000 words of Members of Parliament's speeches for and against the ultimately unsuccessful Assisted Dying (No. 2) Bill 2015. Three elements of the proposed legislation are analysed: the act of ending one's own life, the notion of 'choice' and the role of medical supervision, and emergent discourses are identified and contrasted across both sides of the debate. Finally, the fifth section summarizes the main trends in discourse-oriented studies of assisted dying and considers how this research area might develop in the future.

The broad concept we have so far termed 'assisted dying' goes by many names, including (among others): euthanasia, assisted suicide, physician-assisted death and medically assisted suicide. At points throughout the second and third sections we use these terms somewhat interchangeably, reflecting the particular terms used within the given studies being discussed. Nevertheless, we acknowledge that bioethicists might use these terms to denote slightly different phenomena (see Lamers and Williams 2016; Paterson 2007; Brock 2009). Furthermore, we are sympathetic to Kubiak's (2015) view that, while technically distinct from a bioethical perspective, the concepts denoted by these terms share important similarities, for example: the active role played by doctors who deliver the means to die, congruency between the intentions of the patient and doctor to end the patient's life and the

choice belonging fully to the patient. These points notwithstanding, we acknowledge that any term we use is contestable and liable to redefinition in the future.

2. Assisted Dying

The ways that humans experience and understand death and dying have changed profoundly through the ages. Kastenbaum (2000) observes how dying has largely transformed from something that happened quickly, at a younger age, and at home, into a generally far slower process that tends to occur at an older age, with the moment of death often taking place in a clinical setting. Significantly, medical advances mean people with chronic and acute health problems now tend to live far longer than was possible in the past. Indeed, medical technologies mean that people experiencing health problems can now be kept alive artificially far beyond the point at which their underlying health condition would have, in the past, caused their death (Shim et al. 2006). A consequence of this is that the timing, location and manner of death are all matters that are increasingly determined by physicians and the limits of modern medicine. As Lamers and Williams (2016: 1072) point out, '[t]reatment can be withheld or withdrawn, treatment for pain relief or other symptoms can be increased, even though this may hasten the end of life, or patients can be kept in deep sedation until death without being given nutrition or hydration'. Such life-prolonging technologies have, as Karsoho et al. (2017) argue, created new forms of dying (e.g., neurovegetative state) while remaking moral frameworks at the end of life.

Death has thus become an increasingly institutionalized process, transforming from 'a family affair to something that is professionally managed' (Lamers and Williams 2016: 1072). Kubiak (2015) invokes Foucault's (1977) notion of 'biopower' to account for this capacity of medicine to exert itself over the social practices surrounding death. Kaufman (2015: 7) exemplifies this phenomenon through the observation that therapies originally intended as last-resort options (e.g., implantable cardiac defibrillators) have increasingly become viewed as standard forms of care, thereby becoming 'ethically necessary and therefore difficult, if not impossible, for physicians, patients, and families to refuse'. A corollary of this ethical imperative is that 'few know when that line between life-giving therapies and too much treatment is about to be crossed . . . the widespread lament about where that line is located and what to do about it grows ever louder' (Kaufman 2015: 2). Karsoho et al. (2017) suggest that the use of such life-extending technologies both enables and is enabled by the organizing principle of mainstream medicine; what they describe as the (mistaken) belief that medical intervention can be used to prolong life almost indefinitely— a belief that is linked in turn to a 'prolongevist' ideology (Dumas and Turner 2007). The power of mainstream medicine within contemporary societies is such that its governing 'prolongevist' ideology, which has widely attained cultural as well as institutional (medical) dominance, dictates that the use of life-prolonging treatments is regarded not only as a medical standard but, in a context where death is generally viewed as something that is bad and to be avoided at all costs, a moral and ethical obligation.

A further consequence of society's increasing dependence on, and normalization of, life-prolonging medical treatments is that death itself has become medicalized. Conrad (1992: 209) defines medicalization as the 'process by which nonmedical problems become defined and treated as medical problems'. Medicalization is broadly framed around the notion that 'some undesirable condition or problematic human activity previously lying outside the scope of "the medical model" . . . has in popular thinking and/or public policy been brought within its purview' (Lowenberg and Davis 1994: 582). Ost (2010: 501–2) argues that 'for as long as

we have relied on medicine and physicians in our attempts to prolong life and keep death at bay, death and medicalization have gradually and increasingly gone hand in hand'. Put another way, 'dying has become an illness' (Kennedy 1981), with death becoming, in many cases, 'a medical event' (Ost 2010: 502). Critics of the medicalization of death argue that although the majority of deaths involve some element of medical intervention, such medicalized aspects are actually absent from universal notions of a 'good death' (Seale and van der Geest 2004). Critics also argue that such medical intervention, and the prolongivist principle that often guides it, may result in the extension of life which lacks in quality to those experiencing it (Ost 2010). Certain developments in end-of-life care, such as the palliative care and natural death movements, can be viewed as attempts to de-medicalize death and give individuals more control over how they die (Ost 2010). Medical dominance over death has also been challenged through what is broadly known as the 'right to die' movement, which is concerned with 'redefining the individual's identity, and their relationship with and control of their body as it approaches death' (McInerney 2006: 654). The notion of power is important, then, for interpreting practices and understandings relating to death and how these have changed over time (as well as how they vary between cultures – discussed in the next section). This is because as aspects of life (including death) enter into the domain of medicine through the process of medicalization, they are increasingly subjected to the power of medical institutions (Conrad 1992). Debates around assisted dying have, likewise, engaged directly and frequently with issues relating to power. Indeed, arguments in favour of the 'right to die' have largely been driven by the perception that individuals have increasingly been forced to relinquish control over their deaths. In this context, the right of individuals to choose when, where and how they die is framed as a means through which those individuals can reclaim autonomy over the circumstances of their death.

Individuals who decide to end their life, due to a medical condition or any other reason, can commit suicide using different medical and non-medical means. However, those who are physically unable to end their own life may require the assistance of another. This is broadly what we refer to in this chapter as 'assisted dying', and it has been practised throughout history. For example, Brown (2018) observes how in ancient Greece and Rome, suicide was considered a rational act in cases where the individual concerned had become burdensome to themselves, their family or society more widely. The modern 'right to die' movement, as we might recognize it today, is widely understood to have begun with the founding of the Voluntary Euthanasia Society in England in 1935 (Brown 2018). While a bill which sought to legalize euthanasia in cases of terminal illness was defeated by the UK House of Lords in 1936, it was nevertheless common knowledge that euthanasia was practised by physicians of the day (Brown 2018).

The contemporary legal and ethical landscape regarding assisted dying is complex to say the least. An important distinction here is that between what is often termed 'passive euthanasia' and 'active euthanasia'. Passive euthanasia broadly refers to the act of forgoing medical treatment in the knowledge that this act will result in death. Active euthanasia, also known as 'physician-assisted suicide', involves hastening death using lethal drugs, on the request of the patient or another competent person representing the patient's wishes (Brown 2018). Passive euthanasia is relatively uncontroversial and is even considered acceptable within some religious traditions, as it is the underlying illness – rather than any human agent – that is viewed as causing death. Indeed, in many countries, sick, including terminally ill, adults have a right to refuse medical treatment. On the other hand, active euthanasia is a more

controversial practice. At the time of writing, active euthanasia remains illegal in the vast majority of countries and is considered unacceptable within

religious traditions which emphasize God's authority to determine matters of life and death (Brown 2018). At the time of writing, active euthanasia, in one form or another, is legal at a national level in Belgium, Canada, Colombia, Luxembourg, the Netherlands, New Zealand, Spain and Switzerland. As noted earlier, the 'right to die' movement can be interpreted as an attempt to resist medical dominance over the process of dying. Yet, and as the previous paragraph attests, 'legal, ethical, and social discourses surrounding assisted dying and laws that have permitted Assisted Dying have tended to focus on the assistance of doctors, the provision of medicine to cause death, and medical grounds for requesting death, that is, pain and suffering derived from medical conditions' (Ost 2010: 503). The dominant frame which governs the discourse and practices surrounding assisted dying is thus, somewhat paradoxically, a medical one. As Ost puts it, 'assisted dying has been most commonly presented within a medicalized framework – a framework revolving around medical concepts and terminology, illnesses and medical professionals'. An apt demonstration of this, Ost continues, is in the requirement of medical assistance indicated in the commonly used term, 'physician-assisted suicide'. Salem (1999: 32) contends that physician-assisted suicide . . . presupposes that medicine has passed judgment on the act of suicide . . . as long as the physician is in charge of assisting the patient – either by his or her presence or by supplying the medical means to perform the act – physician-assisted suicide entails the medicalisation of the act of suicide . . . the decision to die by suicide is treated precisely as if it were a set of clinical problems to be solved medically – the 'private', 'intimate', 'self-determining' decision to commit suicide is translated into a clinical event.

Weicht and Forchnter (2023: 434) rightly point out that 'debates over euthanasia are deeply polarized . . . and groups in society engage in discursive struggles over the definition of the issue, its causal interpretation and moral evaluation'. Street and Kissane (2001: 162) further observe how these debates have been contested on numerous fronts, including 'issues of personal vs. social rights . . .; questions of theological, ethical or moral significance . . .; decisions on medical authority and community values . . .; and disputes on the scope of medical intervention, nursing practice and palliation'. In the next section, we consider research which has explored how these debates, along with other social practices which surround and constitute assisted dying, are negotiated through language use or discourse.

3. Discourses of Assisted Dying

Significantly, the social practices surrounding assisted dying – like those surrounding broader health and illness social practices (Brookes and Hunt 2021) – are mediated through discourse. Weicht and Forchnter (2023: 434) describe the 'discursive struggles' that take place over the definition, interpretation and evaluation of assisted dying within society. Street and Kissane (2001: 162) note how 'the discourses that animate these debates are constructed and defended from within social, moral, religious, medical and ethical positions'. Importantly, the process of medicalization is also widely acknowledged to be an at least partly discursive process (Brookes 2018).

The majority of linguistic and discourse-based studies on assisted dying have focused on media representations of the issue and debates around it. Such mediated representations can shape understandings and perceptions of assisted dying. For example, Booth and Blake (2022: 107) argue that '[w]hile few people have direct experience of death and dying, media

contextualize much of what we know about health, illness and dying'. Studies of media representations have tended to focus on coverage surrounding specific events or flashpoints in the assisted dying debate. For example, McInerney (2006) examined the Australian press's discursive representations of dying, death and medicine between 1995 and 1997, a period that marked the passage of the Northern Territory of Australia's Rights of the Terminally Ill Act of 1995, which allowed for lawful euthanasia and physician-assisted suicide for the first time anywhere in the world. McInerney's analysis identified how the media's penchant for reporting dramatic and unusual deaths coincided with the 'requested death' movement's construction of contemporary dying as horrific, intractable and intolerable. McInerney (2006: 655) described the dominance of a 'heroic discourse' which was couched within a dramatic framing which 'served to reinforce many of the claims of the requested death movement'. More recently, Booth and Blake (2022) used a Foucault-inspired approach to Discourse Analysis to examine how Aotearoa New Zealand media discourses enabled particular perspectives on assisted dying in early 2018, following two years of public discussion and parliamentary debate in regard to the referendum on the issue in the country. They identified two broadly oppositional sets of discourses. The pro-assisted dying, 'autonomous right to choose' discourse gave rise to two subject positions: 'my choice and mine alone' and the 'defender of rights'. This discourse 'transmitted neoliberal ideals of individualism, choice, and rationality and produced euthanasia as the right of the Western-privileged subject', while also 'undermin[ing] the power of Church and expos[ing] the struggles between Medicine and individual autonomy in matters related to the dying process' (Booth and Blake 2020: 13). A marginal counter-discourse positioned assisted dying as perilous for society, while the subject position of 'concerned protector' was observed as a means of resisting the dominant 'autonomous right to choose' discourse.

Booth and Blake (2022) were critical of the dominance of the Western perspective over these media representations, particularly in relation to the majority 'autonomous right to choose' discourse, which they argued marginalized non-Western perspectives as well as wider issues relating to health inequality in New Zealand. As the authors put it, '[n]on-Western understandings were absent, religious and spiritual considerations marginalized, the disabled body let die, and the older adult voice silent' (2022: 107). A consequence of this 'selective portrayal', as the authors put it, is that it 'risks harm to non-dominant cultures and groups that engage with mainstream media', while in 'focusing strongly on the rights of the individual to choose a death of their liking, other important issues such as culturally appropriate healthcare, equal quality and material resources are hidden' (Booth and Blake 2020: 107). Other studies of media portrayals of assisted dying have focused on reporting around specific cases. For example, Carpentier and van Brussel (2012) use 'discourse-theoretical analysis' to identify constructions of 'good deaths' in north Belgian newspaper coverage of three euthanasia cases in 2008. Their analysis demonstrates the privileging of the 'right to die' perspective (and variants of it). This is often accompanied by what the authors describe as the 'symbolic annihilation' of other ways of dying. A corollary of these mutually enforcing discourses, the authors contend, is media curtailment of the 'richness of ways of dying that characterize contemporary social realities' (Carpentier and van Brussel 2012). Emerging from studies on media depictions of the assisted dying debate, then, is a profile of broadly opposing sets of discourses which respectively characterize pro- and anti-assisted dying positions. Weicht and Forchtner (2023) set out to compare the discourses underpinning these positions systematically. They examined the discursive articulation of arguments in favour of and opposed to the extension of legislation on euthanasia in Dutch newspapers representing three ideological positions: liberal, religious and humanist. Their analysis demonstrated how the debate developed around three main argumentation strategies, or

‘topoi’: the topos of autonomy, the topos of human worth and the topos of embeddedness. The various discursive positions situated along these topoi are shown to articulate differing versions of ‘legitimate’ death and ‘proper’ ways of ending completed lives.

Another variable that has guided the organization and analysis of data representing newspaper reporting on assisted dying relates to the country of origin. For example, Grego and Vicentini (2019) compared the discourse surrounding ‘medically assisted death’ in British and Italian news media. Their Critical Discourse Analysis focused on the discursive representation of actors, ideologies and ‘cultural aspects’. They found that the British and Italian media focused on the same social actors, and both countries’ reporting exhibited powerful religious (Christian) ideologies. There were also some cultural differences, especially regarding distinctions between the countries’ legal systems and with respect to reporting on specific cases of British or Italian citizens whose stories were framed as contributing to awareness-raising and political debates.

As we saw in the second section, debates and practices surrounding assisted dying have been dominated by the domain of medicine, being viewed and debated through a medical frame. Despite this reality, so-called ‘expert’ discourses around assisted dying have received relatively scant attention in discourse-oriented research. Mediated representations of expert positions on assisted dying have been studied, though, for example by Wright et al. (2015) who carried out a discourse analysis of English- and French-language Canadian print media reporting on physicians’ perspectives on end-of-life care. They identified three main discourses about physicians’ views on euthanasia. These are: contentions about integrating euthanasia within the basic mission of medicine; assertions about whether euthanasia can be distinguished from other end-of-life medical practices; and palliative care advocacy. Notably, while some medical professional bodies were represented as being supportive of the movement towards legalizing euthanasia, individual physicians tended to be depicted as being opposed. For Wright et al. (2015), this raised issues around the extent to which media depictions based on the perspectives of professional bodies can, in fact, accurately represent the views of individual physicians, all the while nevertheless wielding considerable influence in shaping public opinion and policy.

Research on assisted dying representation has also explored discourse produced by members of the public. Jaye et al. (2021) examined the discourse characterizing the voluntary euthanasia debate on social media posts from New Zealand citizens. The posts were found to encode deeply embedded sociocultural values and tensions surrounding citizens and government apparatus, encompassing a more complex range of positions than simply being either ‘for’ and ‘against’. Debates centred on the validity and urgency of the issue relative to other social issues, terminological disputes, the legitimacy of authority to speak on the issue, and the role of the media in shaping such debates. Some posts also contested the authority of religious, legal and medical perspectives, including a broader challenging of the privileging of traditional voices of authority over citizens’ voices. Jaye et al. (2021) argued that the intricacies of the positions articulated in this context problematized binary and simplistic conclusions about public views on assisted dying.

The discourses articulating lived experiences of assisted dying have also been accessed through ethnographic methods, for example Norwood’s (2009) Netherlands-based ethnographic study examining how general practitioners, families and patients talk about euthanasia, and how euthanasia provides a script for thinking, feeling and acting at the end of life. Street and Kissane (2001) also studied lived perspectives on assisted dying through

textual analysis of interviews with, and letters written by, people seeking euthanasia, medical reports, coroner records and media reporting, all based on a sample of cases from Australia. Their analysis focused on four discourses which shaped decision-making in those who opted for euthanasia: ‘the symptomatic body’, ‘the dependent body’, ‘the shameful body’ and ‘the temporal body’. More recently, Lamers and Williams (2016) explored the positions of older people in the euthanasia/assisted dying debate through a Foucauldian analysis of interview data. The analysts identified a ‘confused and conflicted’ discourse, the view that assisted dying is a family affair, and the articulation of a sense of self-determination. While the medicalization of dying, in the form of medical control and surveillance, was endorsed by the participants, the researchers also noted the emergence of an alternative discourse of ‘dying outside the medical gaze’. Participants in favour of assisted dying articulated feeling ‘voiceless’, as well as the feeling that physicians and politicians were reluctant to engage with their perspectives. Participants anticipating poor professional care later in life perceived assisted dying as a way of avoiding this life stage and an associated loss of dignity.

4. Case Study

This case study examines the discourse surrounding assisted dying in the parliamentary debate in relation to the Assisted Dying (No. 2) Bill 2015, the previous time the issue was debated in the democratically elected House of Commons in the UK, before the debate in 2025. The long title of the bill was: to enable competent adults who are terminally ill to choose to be provided with medically supervised assistance to end their own life. The bill was a Private Member’s Bill, introduced to the House of Commons by Labour Member of Parliament (MP) Rob Marris. Bills must go through set stages to become law, starting with a ‘first reading’, a very short process in which the title of the bill is read out and an order is made for the bill to be printed. The next stage is the ‘second reading’, in which MPs debate the main principles of the bill within a set and strict allocated time. At the end of the debate, MPs vote on whether the bill should proceed to the ‘committee stage’, where each specific part of the bill is debated and amendments are proposed and voted on, before several other stages in both the House of Commons and the House of Lords. The Assisted Dying (No. 2) Bill was voted down at second reading and did not progress past this stage, with 117 MPs voting for the bill and 329 voting against.

The data for this study is the transcript of the full second reading debate of the bill (11 September 2015), which lasted four hours and eighteen minutes. The transcript is taken from the UK Parliament Hansard.¹ At the second reading, Rob Marris as the sponsor for the bill opened the debate, followed by speeches from fifty-nine other MPs in which they presented their opinion on assisted dying, the bill and, usually in this case, the way that they intend to vote. Of the sixty MPs who had the time to contribute to the debate, sixteen supported it and forty-four opposed it. In total, the debate comprises 38,431 words, made up of 13,232 words from the ‘Ayes’ (MPs who voted in favour of the bill) and 25,199 words from the ‘Noes’ (MPs who voted against).

The analytical approach taken in this case study is guided by Critical Discourse Analysis. CDA can be described as ‘a type of discourse analytical research that primarily studies the way social power abuse, dominance, and inequality are enacted, reproduced, and resisted by text and talk in the social and political context’ (van Dijk 2015: 466). Specifically, our approach is informed by van Dijk’s (1997: 11) critical discourse analytic approach to political discourse, insofar as it deals with the ‘(re)production of political power, power abuse or domination through political discourse’. Particularly pertinent for van Dijk, and this case

study, is that the political act of law-making and law-debating in parliament is at the same time a political and an entirely discursive practice; forms of text and talk in this context have political functions and implications (van Dijk 1997: 11). Analysing politicians' talk in parliamentary debates allows for the examination of the 'discursive resources employed in a highly influential context' and, in particular, the ways in which 'elites disseminate, reinforce and challenge popular views' about important social issues (Every and Augoustinos 2007: 416). The analysis below explores how assisted dying and issues related to it were discursively constructed by law-makers either in support of or in opposition to the bill, focusing in particular on how these constructions serve the MPs' rhetorical and political aims. Space constraints here preclude the analysis of every interesting or noteworthy pattern in the discourse in this regard, and so we focus on issues that are explicitly mentioned in the long title of the Assisted Dying (No.2) Bill itself: the act of ending one's own life, the notion of 'choice' and the role of medical supervision. The analysis covers the following points:

1. The discursive struggle over the definition of 'assisted dying' and how that permits opponents of the bill to draw on ideologies around suicide to discredit the bill.
2. The discursive construction of different identities for patients in relation to their freedom of choice and control.
3. The discursive construction of the role of doctors in the bill and in assisted dying, both as safeguards and risks.

4.1. Ending of one's own life

A recurring feature of the debate is the terminological struggle between 'assisted dying' and 'assisted suicide', and that those in opposition to the bill consider assisted dying as being akin to suicide and ideologically oppose the bill on that basis. The pervasiveness of this definitional dichotomy is indicated by the frequency of the phrase 'assisted suicide' in the data, appearing almost as often (n=40) as 'assisted dying' itself (n=52).² Both of these terms are used more frequently by MPs who voted against the bill. 'Assisted suicide' appears thirty-eight times (1.51 instances per thousand words (ptw)) in the speeches of 'No' voters compared with only twice (0.15 ptw) in the speeches of those who voted 'Yes'. Similarly, 'assisted dying' is used forty-five times by 'No' MPs (1.79 ptw) compared with six times by 'Yes' MPs (0.45 ptw). Therefore, the 'No'-voting MPs are driving the frequency of both terms, and especially the comparison of 'assisted suicide' and 'assisted dying'. At points in the debate, MPs directly address this distinction, for example (MP's name, vote, and political party given in parentheses):

(1) Before I get into the detail of the arguments, it is important to highlight exactly what we are talking about with assisted suicide. Members can call it assisted death if they wish, but we should be specific.

(Robert Flello, No, Labour)

The distinction between 'assisted dying' and 'assisted suicide' is one which not only recurs throughout the debate but also pre-dates it. In an intervention during Rob Marris's opening speech, an opposition MP asked the bill's sponsor why he did not call it the 'assisted suicide bill', to which Marris responded, 'it is quite simple: it was called the assisted dying bill in the House of Lords'. Marris is making reference to the version of the bill which reached the committee stage in the House of Lords a year earlier. In that debate, Lord Falconer, the sponsor of that iteration of the bill, argued in favour of the term 'assisted dying' that individuals and groups involved in working with and supporting people with regard to suicide

are ‘antipathetic to the words “committing suicide”. There is a moral opprobrium attached to it.’ The national campaign, ‘Dignity in Dying’, which supports the assisted dying bill (and which Rob Marris thanked at the start of his opening speech for its assistance on the bill) also addresses this distinction, emphasizing that ‘dying people who want to control the manner and timing of their deaths are not suicidal’ (Dignity in Dying 2016). This preference for ‘assisted dying’ over ‘assisted suicide’ is somewhat reflected in the higher frequency of the former over the latter in the speeches of MPs in favour of the bill (albeit the numbers are small at six vs two), and supporters of the bill go some way to making the difference between assisted dying and suicide clear, for example:

- (2) Does the hon. Gentleman agree that anyone who has any knowledge of suicide sees it as a desperate and tragic act, committed by somebody in extreme emotional distress? It is usually committed alone, leaving families and loved ones devastated. The desire of a dying person for a peaceful death is so different from what I have just described, and anyone who has any knowledge of suicide would share that view. I believe the hon. Gentleman’s argument to be null and void on that point about suicide.

(Lucy Allan, Yes, Conservative)

On the flip side, by regularly referring to assisted dying as ‘assisted suicide’, opponents of the bill are invoking precisely the ‘moral opprobrium’ mentioned by Lord Falconer, creating the discursive space in which assisted dying can be challenged and opposed on broad moral terms, for example:

- (3) The law has always regarded it as wrong to assist in someone’s suicide because, in the end, we think that suicide is wrong, even if we think that it should not be a criminal offence. That is why we should take the very greatest care before taking this fundamentally different step,

(Nick Herbert, No, Conservative)

- (4) The three main reasons that I oppose the Bill are, first, the normalisation of suicide. Society disapproves of suicide, and if it becomes normalised it becomes an issue of debate for everyone who reaches the end of life.

(Glyn Davies, No, Conservative)

The extracts from these speeches position suicide as something that society is opposed to; it is ‘wrong’ and ‘disapproved’, and it is implied that the Assisted Dying Bill would risk encouraging, approving and ‘normalizing’ suicide. The logic is, therefore, that because suicide is ‘wrong’ and assisted dying is really assisted suicide, then assisted dying cannot possibly be supported. Suicide has historically been stigmatized by societies; some of the more repressive rituals of the Middle Ages included the mutilation of suicide corpses to prevent the unleashing of evil spirits into the community. Although such rituals are no longer practised today (Cvinar 2005: 14), suicide is still often construed as weakness, a lack of faith and ‘madness’ (Tadros and Jolley 2001: 178), suicide attempters are dismissed as attention-seeking (Sudak et al. 2008: 137) and the families of those who have died by suicide are often the targets of social disapproval, isolation and shunning (Feigelman et al. 2009: 592). Those in opposition to the bill therefore not only reflect and reinforce the notion that ‘suicide is one of the most stigmatising acts’ (Galasiński 2017: 1), but rely on this stigma to undermine the case for assisted dying. At the heart of this opposition to the bill is that ending one’s own life, under any circumstance, is not something that Parliament, the government or society at large can morally accept, much less support.

4.2. *Freedom of 'choice'*

Central to this bill is the notion of choice. The passing of the assisted dying bill would not make assisted dying compulsory, but it would give those individuals who fall within the law's remit the choice to end their lives through assisted dying. Those in support of the bill emphasize that it would give terminally ill people some control over how they die:

- (5) This Bill will enable people to have peace of mind. We do not know – we do it only once – what our death will be like, but I would like to give people the peace of mind that if the situation becomes intolerable, they can make an informed choice about their own life.

(Sarah Champion, Yes, Labour)

- (6) I and many others would find it comforting to know that the choice was available – to have the option of choosing a dignified and peaceful end at a time and place and in a manner of my own choosing at my own hand.

(Rob Marris, Yes, Labour)

Arguments in support of the bill present assisted dying as a freedom afforded to terminally ill people to have control over the timing of their death if their situation becomes intolerable (example 5) in order to bring their lives to dignified and peaceful end on their own terms (example 6). It is constructed as a compassionate way to allow someone to end the suffering that they may be enduring. This way, those who choose (or would choose) assisted dying are constructed as being liberated agents in control of their own fate; in other words, it is their chance to have a 'good death'. For opponents of the bill, assisted dying (or assisted suicide, as they see it) does not bring dignity in death and is not a 'good' way to die. This is graphically outlined by Conservative MP Nadine Dorries, an opponent of the bill, who described the procedure of assisted dying as the patient 'choking' on 'poison' in a 'painful and barbaric' way to die. Instead, for Dorries and many other members opposed to the bill, it is palliative care which offers a dignified and peaceful death. Indeed, throughout the debate end-of-life care is a discursively constructed opposition point to assisted dying, and despite the availability of good quality palliative care and access to assisted dying not being mutually exclusive, opponents of the bill construct the two in competition with each other. In some instances, this is a competition for resources, as it is argued by some members that the availability of assisted dying will discourage investment of funding in palliative care. More commonly, however, the competition is constructed as the burden of choice for individuals between dying as a result of their illness or through assisted dying:

- (7) As has been said, many people are desperate when first diagnosed with a terminal illness. It is completely understandable, and it is easy to make a rash decision. Many feel a burden on their family and wish to die to alleviate that burden, when actually that family love them, want to care for them and do not want them to die. The way to alleviate distress in dying people and their families is to care for them properly with good palliative care, not to murder them.

(Andrew Bridgen, No, Conservative)

In this example, and elsewhere in the debate, terminally ill patients ending their lives in palliative care is constructed as the 'right' way to die, or at least as the 'right' way that they should be cared for by society. This stance not only contributes to the perception of those who

die by suicide as deviant as compared with those who die as a result of illness (e.g., Sand et al. 2013) but also reconfigures the agency of the patient. Rather than being in control of their own deaths, as supporters of the bill would argue, the opposing argument is that those who have an assisted death are constructed as victims. In the particularly extreme case of example 7, they are represented as victims of ‘murder’, but a more common type of victimhood, also evidenced in this example, is that in which terminally ill, elderly and disabled people are put under pressure to end their own lives through assisted dying because they consider themselves a burden to their relatives and society. This is one of the main arguments made against assisted dying and the bill throughout the whole debate and is drawn on by most opponents of the bill. Patients with terminal illnesses and chronic pain perceive themselves as ‘a burden to others’ and this contributes to an increased risk of suicidal ideation (Wilson et al. 2017). Opponents of the bill again, as we saw earlier, broaden this view and couch it within the notion of ‘society’:

- (8) What sort of society do we want to create? Do we want to create one in which we solve our problems by killing? . . . I would at least ask them this question: ‘What sort of society do we want to create when we feel that we can solve problems by hastening death rather than promoting life?’ What sort of society are we creating if we say that we value people who are healthy, fit, beautiful and young more than we value people who are poor, old, crippled, ill and dying?

(Sir Edward Leigh, No, Conservative)

In quite a contrast to the image of terminally ill patients having the choice to end their lives on their own terms, here they are constructed as second-class citizens, victims of the state which, by providing the option for assisted dying, has created an unbearable burden of choice for some of the most vulnerable people in society.

Opponents of the bill stress that terminally ill (and potentially elderly and disabled people, should the remit of the bill be extended in future – the so-called ‘slippery slope’ argument) will not only feel self-imposed pressure to end their lives through assisted dying, but also pressure from family members, and that ‘vulnerable old people could be coerced into taking their own lives by unscrupulous or heartless relatives or beneficiaries’ (Andrew Bridgen, Conservative). This challenge is perhaps best summarized in this extract:

- (9) It is naive to believe that we can prevent an elderly, expensive or asset-rich relative being encouraged, coerced or emotionally blackmailed into taking their own life. And if just one person makes that decision to end their life as a result of such pressure, that would be a tragedy.

(Lyn Brown, No, Labour)

Here, the identity of those to whom the assisted dying bill would apply are conceptualized as victims at risk of being forced to kill themselves. Those people are put at risk by a piece of legislation which does not provide a choice, but rather permits coercion and results in a process that amounts to murder and killing. From this view, the bill does not enable competent adults to choose when to end their own lives, as its long title claims, but increases the likelihood of some of the most vulnerable in society being forced, one way or another, to end their lives early for the benefit of others.

4.3. *Medically supervised assistance*

Much is made by supporters of the assisted dying bill of the ‘safeguards’ that it provides to protect against the sorts of pressure and coercion outlined above – the procedural due-diligence that has to be completed to ensure that people are not forced into assisted dying against their will. In brief, the process is that two independent doctors must sign a declaration that the patient is terminally ill, with less than six months to live, of sound mind and acting voluntarily, before the counter-signed declaration is given to a High Court judge to make an order. Although the role of the High Court in the process is criticized by many in the debate, the focus here is on the ways in which doctors are invoked by supporters of the bill, and how those opposed emphasize the pressure under which the bill will put doctors and the effect it will have on doctor–patient relationships. MPs in favour of the bill implicate doctors and medical professionals in a number of ways when exercising their support for assisted dying. For some, this is by means of an explicit description of the apparent safeguards that doctors will provide against the forced use of assisted dying, for example:

- (10) On coercion, I do not doubt that perhaps there are evil relatives out there who will seek to coerce their elderly mother. However, that elderly mother will then have to persuade two doctors and a judge that this is her choice.

(Sarah Champion, Yes, Labour)

Elsewhere, it is emphasized that there is an ‘opt-out’ for doctors who do not wish to be party to a case of assisted dying, and that this change in the doctor–patient relationship is a positive move:

- (11) Many Members have expressed concern as to the role of the medical profession, saying that there would be a fundamental change in the doctor–patient relationship. . . . There is an opt-out for medical practitioners, and some would say that that heralds a more mature relationship between doctors and patients.

(Andrew Slaughter, Yes, Labour)

Meanwhile, others express their support for the assisted dying bill by claiming that doctors already enact a sort-of-assisted-dying to terminally ill patients. One supporter of the bill, Kit Malthouse (Conservative), states that ‘that the reality is already here. Doctors are hastening and helping people to their deaths every day.’ This is a view shared by other MPs:

- (12) Doctors will go on giving just that little bit more morphine to a dying patient to relieve unbearable pain, knowing that it could lead to death.

(Lucy Allen, Yes, Conservative)

For these supporters, the bill is not welcomed necessarily because it grants brand new freedoms, but instead because it provides clarity for health professionals and brings the law up to speed with what is already happening.

In contrast, for those opposed to the bill, the changing nature of the doctor–patient relationship cannot be countenanced, and they argue that the bill would have far-reaching social implications in that regard. In stark opposition to Andrew Slaughter’s argument above, the consensus in the ‘No’ camp is that the introduction of assisted dying would fundamentally damage the doctor–patient relationship:

- (13) The third reason that I oppose it is that it inevitably changes the relationship between doctors and their patients. A doctor’s job has always been to do no harm.

People go to the doctor because they want the doctor to help them and make them well. If assisted dying will always be part of their discussions, it will interfere with that relationship for ever.

(Glyn Davies, No, Conservative)

This example is the clearest demonstration of the discursive strategy used on many occasions in the speeches of opposed members, which involves emphasizing doctors' commitment 'to do no harm', to provide a version of what patients expect of doctors ('to help them and make them feel well') and to claim that the assisted dying bill would inevitably and irreversibly change this relationship. This strategy appeals to a fear of change, and particularly a change that increases risk to vulnerable people, and this rationalizes the necessity for the bill to be voted against.

It has been noted above that those in opposition to the bill emphasize that it has the potential to put pressure on terminally ill people to end their lives. In the same way, those against the bill bring to the fore the additional pressures that the legalization of assisted dying as defined in the bill would put doctors under:

(14) It is of course impossible, as experts in end-of-life care will affirm, to know definitively how long a person will live. Under the terms of the Bill, we would be asking doctors to make life or death decisions about matters about which there can be absolutely no clinical certainty.

(Colleen Fletcher, No, Labour)

(15) Doctors can come under enormous pressure from relatives and from their own emotions to hasten the death of a patient whom they believe to be suffering too much. . . . I believe that anything that increases such pressures on doctors opens up an ethical trap that we do not want.

(Dr Liam Fox, No, Conservative)

Extracts 14 and 15 pinpoint two particular pressures faced by doctors should the bill be passed: pressure to accurately give a six-month prognosis and pressure by families to end their loved ones' pain. Here, doctors are simultaneously constructed in two different ways, both of which ultimately serve to attack the bill. On the one hand, they are victimized, as the bill is seen to place unreasonable and unfair demands on medical professionals, and for this reason the bill must not be passed. On the other hand, a focus on these pressures may also implicitly undermine doctors' professional competency, questioning their ability to provide accurate prognoses, as well as their resolve to resist the demands of patients' families. Regardless of which interpretation is intended (or indeed perceived), the effect is the same: serious doubts are raised regarding the so-called 'safeguards' offered by the medical profession in the process of assisted dying. On this basis, its opponents argue, the bill cannot be passed.

5. Conclusions

This chapter has explored the language use, or discourse, that characterizes practices which surround, and indeed constitute, assisted dying. As we hope to have demonstrated, discourse is a central concern in such practices – from defining and debating what assisted dying is, through to the discursive practices involved in requesting the end of one's life, and, for practitioners, approving and consenting to being involved in the process. Discourse-based

inquiry into the language use and texts which surround and constitute assisted dying therefore has the potential to reveal much in terms of how this phenomenon is understood, contested, evaluated and experienced within society. As our review has shown, most discourse-based research on this topic has focused on media representations – such depictions are an important site for investigation, having the potential to reflect and also shape attitudes held towards assisted dying by many in society. However, and importantly, the discursive struggles surrounding assisted dying are played out not just on the pages of newspapers, but across a wide range of contexts. Research in this area should therefore aim at better capturing the potential diversity of discourses underpinning assisted dying by examining, and indeed comparing more systematically, how such discourses reify and are utilized across contexts representing the perspectives of a range of different groups or stakeholders, including, inter alia, medical professionals, politicians, patients and the public more generally. Likewise, given the cultural contingency of attitudes and practices surrounding assisted dying, more systematic comparison of discourses surrounding this topic across different cultural contexts would have to denaturalize taken-for-granted attitudes and perceptions which, along with religious interpretation, guide current legislation.

In this chapter, we have sought to extend further the reach of discourse-based research on assisted dying by examining the discourses that characterize political debate around the topic in the UK. Our case study found that pro- and anti- discourses surrounding assisted dying construct opposing representations of the morality of taking one's life, contrast freedom of choice with burden of choice, take different views of control versus coercion and present the role of doctors as being simultaneously agents of safeguarding and agents of risk. These issues were at the heart of the Assisted Dying (No 2.) Bill 2015 in which UK MPs debated, and ultimately voted against, developing legislation on this issue. What is clear from the debate is that, for law-makers, the practice of assisted dying has implications for fundamental societal understandings of 'good deaths' and 'bad deaths'; the relationship between the sanctity of life and dignity in death; and how a responsible government should view the terminally ill. In 2025, the Terminally Ill Adults (End of Life) Bill passed all of the stages in the House of Commons, and at the time of writing is being debated in the House of Lords. Whatever the legislative future holds for assisted dying, it is almost certain that the contrasting discourses observed in this chapter, both in our case study and the research we have reviewed, will continue to characterize the debate.

Notes

1. <https://bills.parliament.uk/bills/1631/stages/7835>.
2. This excludes eight instances in which 'assisted dying' is said in reference to the specific name of the bill being debated.

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