Freedom v. *Protection* (v. *Fence-Sitting*) Narratives in the Euthanasia Debate:
A Qualitative Narrative Policy Analysis of Canadian Media from 2007-2017

by

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Abstract

In 2016, Gray and Jones adapted the narrative policy framework (NPF) to a qualitative context. In this research, I build from their resulting Qualitative NPF (Q-NPF) method to analyze 300 randomly selected Canadian media articles published between 2007-2017 on the topic of Medical Assistance In Dying (MAID). I begin by explaining how the concrete procedures of MAID are distinct from other end-of-life practices, and introduce the terminology that will be used throughout this research. I then introduce historic and academic literature relevant to the form and content of the contemporary media narratives to be analyzed, especially drawing theoretically from Rose's (2013) discussion of biomedical personhood discourses and Butler's theory of unevenly distributed precarity. I then explain the methodology of qualitative narrative policy analysis (Q-NPF), and apply it to Canada's MAID debate by dividing the policy positions into what I call the *Freedom*, *Protection*, and *Fence-sitting* narrative policy camps. The *Freedom* camp advocated for MAID legalization; the *Protection* camp advocated against MAID legalization; and the *Fence-sitting* camp avoided advocating either for or against baseline legalization of MAID, instead weighing in only on peripheral issues. I discuss the qualitative differences of narrative content specific to these three camps, highlighting the most prominent narrative trends (by frequency of publication) and discussing the ways in which these findings either accord with or contradict the expectations of the literature review. Finally, I update the reader on Canadian legislative developments since 2017 and identify how the data of 2007-2017 anticipated these developments, demonstrating the salience and predictive power of Q-NPF. I conclude by proposing new directions for potential investigation.

Keywords:

Euthanasia, Physician Assisted Suicide, Medical Assistance in Dying, Canada, Qualitative Narrative Policy Analysis

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

A Thought Experiment

Imagine the following: Your friend, whom we will call Sasha, has cancer. Sasha's condition is terminal, deteriorating, and her treatment plan involves ongoing physical pain management by medical means, including morphine. The morphine effectively manages Sasha's physical pain, although she wishes it left her clear-headed for conversations with her family. One day, you check in with Sasha and she tells you she would prefer death over deterioration – and she has a specific sort of death in mind. (Sasha has been reading medical manuals in her spare time, and she knows her stuff.) She asks to be injected with a specific series of drugs in a sequence of injections spread across five minutes: first midazolam (to induce sleep) and propofol (to induce a coma), then rocuronium (a neuromuscular blocking agent) to paralyze her diaphragm, to directly and immediately end her life by respiratory arrest. Finally, Sasha requests that if the rocuronium fails to end her life within five minutes, she be injected with bupivacaine to induce cardiac arrest.

In case this thought experiment seems simple to you, consider the following variations.

What if:

- Sasha doesn't have terminal cancer, but instead has a non-terminal physical illness, with which she might foreseeably live another 40-60 years without intervention?
- Sasha has no physical illness, but has treatment-resistant depression?
- Sasha is twelve years old and makes the same request for herself? What if Sasha is eleven months old and her parents make the request on her behalf?
- Sasha has no illness, but is confined to a wheelchair and considers this disability subjectively intolerable?
- And, finally, imagine that Sasha has neither physical nor mental illness, but instead fears eventually developing dementia, and requests – today – that this procedure be performed in the

hypothetical 'tomorrow' if she develops dementia. However, after developing dementia (and therefore no longer judged cognitively competent, under prevailing medical norms, to make her own care decisions) she states a preference to live or otherwise seems to prefer to live. Either simplifying or further complicating the issue: What if Sasha imagines this scenario in advance and specifies that even if she seems happy with her life while cognitively declined, and even if she physically fights back and says "I don't want to die" at the moment of lethal injection, she wants prioritized the choice that she is making now – made while still judged cognitively competent – that lethal injection will be administered to her at a pre-determined point after she has been judged no longer cognitively competent?[1]

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[1] Illustrating such complications, consider the 2016 case of a woman in the Netherlands who was euthanized while resisting (details from Regionale Toetsingscommissies Euthanasie, 2017). This woman wrote a "living will" after her Alzheimer's diagnosis, describing herself as "traumatized… severely" by observing her mother's time being "nursed in an institution for 12 years." The living will expressed her desire for eventual voluntary euthanasia before entering an institution – but at an otherwise unspecified moment, when she herself felt the "time was right," wishing to eventually "say a dignified goodbye to my loved ones." Yet she never expressed to her doctor that the time was right. When her husband admitted her full-time to a nursing home, he requested at intake for euthanasia to proceed, but the patient still answered doctors' death-desire questions "in the sense of "Not yet, it's not so bad!"." However, the patient became considered behaviourally "difficult" (described as a "controlling" woman who attempted to direct the other inmates and doctors like children) and her suffering was assessed as "hopeless" (though one consultant doubted the unbearability of her suffering, finding her often "cheerful and satisfied"). It was ultimately concluded that all "due care" criteria had been met, and seven weeks after admittance, euthanasia was arranged without telling the woman. One morning, while enjoying coffee with her husband and adult son and making afternoon plans with them, a sleeping drug was, without her knowledge, placed in her coffee. When the doctor returned to administer lethal injection, the woman awoke, appeared fearful, and kicked the doctor. The family had to physically hold the woman down while injections were completed. The euthanizing doctor later testified that even if the woman had said, "I don't want to die," the doctor would have continued. (Court conclusion in footnote, next page.)

After imagining yourself as the friend in each of these situations, consider: Does your response depend on the scenario? Did you find yourself wondering about the legal status of these injections in these scenarios?

There are physicians who will face these scenarios, and more, over the course of their careers. The sequence of injections our hypothetical Sasha is requesting refers to a real practice, known by many names (see Terminology, page 9). And for many – perhaps most – of the health workers facing such a request, wrestling with what to do will be difficult. Consider that in a multicultural society, some health workers will be devout Orthodox Jews, Catholics, Muslims, Hindus, or members of other religions that similarly consider this act to be an 'unjustifiable killing[2] of the innocent,' even if requested by the innocent. Some health workers may be non-religious humanists with Aristotelian philosophical convictions that similarly contra-indicate performance of this act. A health worker might consider this act a violation of their Hippocratic Oath.[3] Finally, some health workers may be neither religiously affiliated nor philosophically inclined, but may nonetheless have a deep, persistent 'feeling' in their hearts that places them in opposition to this act, even if they struggle to explain their values when

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(Continued from Footnote 1) While the review board concluded that the doctor "crossed a line" first by trying to deprive the woman of an opportunity to resist (by sedation), then by failing to stop when the woman reacted negatively (Regionale Toetsingscommissies Euthanasie, 2017), the doctor was ultimately acquitted of all charges by a Dutch court. The court concluded that the doctor was right to rely on the 'living will' document and not on current organic expressions of patient preference. In the words of the presiding judge: "The court concludes that the doctor did not need to verify the current desire for euthanasia (of the patient)." (Van den Berg, 2019)

[2] See Footnote 6 (p. 10) for clarification about my use of the verb 'To Kill' in the context of this research.

[3] While variations upon the Hippocratic Oath are in use today (different medical students in different contexts may take differently-worded oaths), the Hippocratic Oath in its original formulation includes specific clauses such as: "I will neither give a deadly drug to anyone, though having been asked, nor will I lead the way to such counsel." (Cavanaugh, 2018, p. 58)

challenged to defend them in philosophical language. Alternately, some health workers will have beliefs or values consistent with performing this act, perhaps in additional scenarios beyond those described above. These health workers may struggle with remorse when they feel they are not offering patients the 'compassionate exit' they believe such injections constitute.

In addition, all health workers, regardless of personal feelings and beliefs about this act, will have to factor into their decision-making struggles the institutional norms prevailing in the particular context of their medical practice. For instance, does their state or workplace threaten them with job loss or legal penalty if they perform this act – which a health worker may consider a morally obligatory mercy – under conditions that the state or institution considers inappropriate? Alternatively, does the health worker's state or workplace threaten them with job loss or legal penalty *unless* they perform this act – which a given doctor may consider a morally impermissible violence – or unless they at least participate in the process far enough as to ensure, by effective referral, that this act is performed? While weighing the obligation to follow one's conscience against one's citizenship duties to government and contractual duties to employer, many health workers may also have medical school debt and dependents to support, whose reliance on their continued medical employment and income adds a layer of difficulty to their moral and pragmatic calculus.

It is into this ethical quagmire, most concretely experienced by health workers due to patient proximity, access to relevant substances, and specialized knowledge about the interactions between substances and the human body, that lawyers, judges, and politicians have waded in recent years in Canada. Legal and political figures have argued for and against changes to laws and policies governing such a 'Sasha's request.' Media workers have reported on these debates, presenting their own ideas and selecting how to report the opinions of health workers, activists, and members of the general public. Roughly speaking, the three competing 'policy positions' on this topic can be identified as:

1.) The *Freedom* position (at baseline supporting a policy-legal environment in which it is permitted by law to carry out Sasha's request; see p. 55 for the data-emergent reason for referencing this as the "*Freedom*" position);

2.) The *Protection* position (at baseline supporting a policy-legal environment in which it is prohibited by law to carry out Sasha's request; see p. 88 for the data-emergent reason for referencing this as the "*Protection*" position); and

3.) The *Fence-sitting* position (those 'leftover' policy narratives that avoid advocacy about the baseline legality of this act one way or another, instead advocating only for peripheral causes; see p. 118 for a deeper exploration of the diversity and nuances of *Fence-sitting* narratives).

While carrying out Sasha's request is currently legal, or permitted without prosecution, in at least one country in the world in each of the thought-experiment scenarios above, it would have been illegal across Canada in every scenario prior to 2014. Canada's *Criminal Code* forbade suicide assistance from the time of its first enactment in 1892, and this legal prohibition endured its first constitutional challenge, which took place in the case of Rodriguez v. Canada, 1993. The rationale for preserving this prohibition as 'constitutional', as explained in the decision given by the Canadian Supreme Court of 1993, was that while there were implications for a person's s.7 *Charter* right to security of the person (this understood to encompass the right to "make choices concerning one's own body"), nonetheless the prohibition against suicide assistance was a necessary and proportionately justified provision to protect "the vulnerable" and maintain "respect for human life," consistent with the Canadian legal rationale for prohibiting capital punishment for criminals (Rodriguez v Canada, 1993). The judges in the Rodriguez case – including dissenting judges who favoured decriminalizing the assistance of suicide – notably also rejected the plaintiff's argument that prohibiting suicide assistance constituted 'discrimination' against the physically disabled who cannot effect their own suicide. While Parliament had repealed a separate law against solo suicide in 1972, the judges in the Rodriguez case noted that this had not been intended as "recognition that suicide was to be accepted within Canadian society… [but rather] that the criminal law was an ineffectual and inappropriate tool for dealing with suicide attempts" (Rodriguez v Canada, 1993).[4] In sum, the judges in the Rodriguez case assessed that suicide was, while no longer punished by law, not a 'right' to which a person ought be granted 'access'; they also assessed that mere abstention from assisting in suicide did not constitute "cruel and unusual treatment or punishment" under the law; and they concluded that the "pressing and substantial" goal of protecting the vulnerable – from the risks to which they may be subject in an environment of legal suicide assistance – was, on balance, worth the cost of limiting an individual's right to "autonomy over her person" by prohibiting assistance of her suicide.

Two decades later, Canadian courts revisited this issue, and the law ultimately changed. In 2014, the National Assembly of Quebec passed *Bill 52, an Act respecting end-of-life-care*, to provincially legalize an act it framed as "medical aid in dying" or "death hastening". This bill carefully avoided the terms "assisted suicide" or "euthanasia", in an effort (commentators speculated) to "avoid friction with the Criminal Code of Canada" (Dyer, 2014), though the practice described by the bill was identical in substance to that which the Criminal Code forbade. It was unknown at that time whether Quebec's bill would withstand appeal, given the evident jurisdictional issues of a province passing legislation

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[4] Indeed, the *House of Commons Debates*, 28th Parliament, 4th Session: Vol 2 records members reproducing medicalized discourses of suicide, and ongoing interpretation of suicide as an 'offence' (not a 'right') in coming to their decriminalization decision. One characteristic quote read: "people committing such an offence are obviously sick in their minds… I think that anybody will agree on that" (p. 1795). These parliamentarians continued to frame suicide as a 'problem' – just one requiring a preventative "solution" in the sphere of medicine or social science rather than in "jail." One member did note the potential risk (framed by this member as undesirable) that "repeal of the law would weaken [the moral and religious condemnation of suicide] and cause moral opinion to move in a permissive direction" (p. 1705). However, even this member seemed ultimately to share in the overall consensus of the recorded transcript that decriminalization of attempted suicide, to remove an unhelpful punitive measure, was on balance an appropriate action: "a human approach."

seemingly at odds with federal legislation. However, just one year later, in February of 2015, a separate lawsuit known as *Carter v. Canada* resulted in a federal Supreme Court ruling that reversed its own 1993 *Rodriguez* precedent, now declaring *Criminal Code* s.241(b) "unconstitutional" under certain circumstances. The Carter case was a lawsuit filed by the Vancouver-based BC Civil Liberties Association, with the goal of legalizing the assistance of suicide for the terminally ill. The lawsuit was joined by Gloria Taylor (a B.C. woman diagnosed with ALS) and the daughter of Kay Carter (a B.C. woman with spinal stenosis who had already received suicide assistance in Switzerland). The judges in this case decided that "the matrix of legislative and social facts" had changed since 1993, specifically suggesting that the law relating to the principle of "overbreadth" had "materially advanced since *Rodriguez*", such that it was now appropriate to assess s.241(b) as an unjustifiable infringement on s.7 of the *Charter* (Carter v. Canada, 2015). The *Carter* decision specified that s.241(b) should not apply to a "competent adult person" who

(1) clearly consents to the termination of life and
(2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition. (Carter v. Canada, 2015, para. 4)

The *Carter* decision was announced with a one-year suspension of invalidity (with a constitutional exception for Gloria Taylor so she would not have to wait), to allow time for Parliament to develop and enact a replacement law. After the granting of a subsequent extension, Parliament enacted its amended law 16 months later via Bill C-14, permitting life-ending action under two forms (see definition of 'MAID', p. 15). Qualifying criteria were written to include: eligibility for health services funded by Canadian government, cognitive competence to make health decisions, being aged 18 or older, having made a voluntary request not the result of external pressure, and having given informed consent "after having been informed of the means that are available to relieve their suffering, including palliative care." Crucially, an individual would also need to have a "grievous and irremediable medical condition", defined as "serious," "incurable", "in an advanced state of irreversible decline in capability," and with "natural death" already "reasonably foreseeable." (Bill C-14, 2016, c. 3, s. 241.2) The latter eligibility criterion of reasonable foreseeability was interpreted by many as vague, and earned the new law critique, as will be later illustrated in the Findings and Discussion chapters of this research. Subsequent legal changes have also since unfolded, but these will be discussed in more detail in Chapter 8 of this research.

Suffice for now to say that since June 2016, a doctor in Canada has been legally permitted to carry out Sasha's request in specific, institutionally regulated scenarios. In those scenarios as yet unapproved by Canadian law, one might expect the legal constraint to make the ethical struggle seem simpler for health workers. That is, one might expect a health worker to feel enabled to say, "In this particular case it isn't legal to carry out this request in my country, so I won't talk or think about it further." However, the history of Canada's conversation surrounding this practice reveals that for many health workers, the knowledge that a practice is not codified as legal (yet), does not prevent them from thinking about or, in some cases, performing that practice – however covertly. Indeed, the published narratives analyzed within this research revealed frequent self-disclosures and third-party-descriptions of health workers as individuals who wrestle with felt-tension between private conscience and legal norms like anyone else, sometimes resolving this tension by choosing to align with private conscience, instead of with legal or medical policy norms of their geographic or institutional context.

In sum, regardless of which situational 'Sashas' actually receive the requested procedure in a given context, the sequence of injections requested by Sasha references a real practice, identifiable by a procedural name. In Canada since federal legalization in 2016 (for those circumstances under which the practice is legal), this name is 'Medical Assistance in Dying' (more commonly known as MAID[5], for short). Historically and internationally, and in academic literature, this act has also frequently been referenced as 'euthanasia' or 'physician assisted suicide'.

In the remainder of this introduction, I will define these and other key terms as they will be used throughout this research. These terms, as will be illustrated in chapters four through seven, have become contested in the media consumed by the general public. It will therefore benefit the reader to first understand the sense in which these terms are used in academic literature. In Chapter Two, I will introduce the reader to contemporary theoretical literature which provides a helpful lens for analyzing the media narrative findings under consideration in this research. In Chapter Three, I will describe the methodology which shaped the design of this research, explaining my processes of data collection, data analysis, and the criteria of trustworthiness by which this research may be measured. In Chapters Four, Five, Six, and Seven, I present the findings of this research in the form of narrative elements categorized into ideal 'types', and grouped together into narrative 'camps' with both summaries and media examples of narrative content. Finally, in Chapter Eight, I analytically review and discuss these findings, highlighting connections between the findings, academic literature, and subsequent political developments in Canada, and conclude by proposing fruitful areas for future research.

Terminology

Suicide

Foundationally, I note that the word 'suicide' itself (while considered by some to be a stigmatized or stigmatizing term for reasons that will be reviewed in both the literature review and findings) denotes only, etymologically, 'self-killing'. 'Suicide' derives from the Latin *suī-cīdium:* literally, 'the

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[5] MAID is the acronym used in public-facing government forms, and as will be referenced in this research.

killing[6] of oneself'. In the absence of any equally simple and etymologically precise term for describing this most basic essence of the act in question, I use the word 'suicide' at times, often phrased as 'solo suicide' to distinguish it from the phenomenon of 'assisted suicide' so central to this research). This is intended only to convey the etymologically precise meaning of 'self-killing', not to imply notions of criminality or medicalization as if such cultural connotations are inherent to the term.

Euthanasia

Technically speaking, the word 'euthanasia' etymologically means only 'good death,' from the Greek roots *eu* (good) and *thanatos* (death), and could theoretically be used to refer to any death that a person might call "good," including natural death. However, in contemporary discourse this word always implies an action by a third party to end a life, to relieve or avoid suffering. Philosophers use 'euthanasia' as an umbrella term under which several different practices are subcategorized as 'sub-types' of 'good death'. These subcategories of euthanasia are considered meaningfully distinct by most philosophers (e.g. see Keown, 2002; McLachlan, 2008; and Paterson, 2008), who draw moral and legal distinctions between them, typically permitting some while prohibiting others. However, philosophers who consider these categories meaningfully distinct do not always argue to prohibit a given subcategory of practice. Alternately, the meaningfulness of such distinctions is debated by some, particularly by those who advocate for the legal permissibility of all subcategories. See for example Kuhse (1997) who argued that medical regulatory frameworks should be undergirded only by

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[6] In turn, the word 'killing' in English, though often connoting a negative value judgment, does not necessarily denote a morally wrongful act. It is applicable, for example, to the killing of an animal for food, or the killing of a rose bush by frost. Further, certain forms of human-killing, such as the killing of an enemy combatant in war, or the killing of a convicted criminal, are argued by some to be morally justifiable. The term "to kill," therefore, connotes no inherent value judgment in this paper. If I mean to communicate a value-laden modifying concept (e.g. p. 3 when representing the perspective of world religions), I will use such a modifier (i.e. "unjust") to clearly denote this value judgment.

"procedural safeguards [such] as consent" and avoidance of "medical paternalism," rather than by "mainstream" moral distinctions (e.g. distinctions regarding intention). Nonetheless, for the reader's informed understanding of the contributions made by philosophical systems that recognize more rather than fewer distinctions, I note here the three usual dimensions along which philosophers subcategorize euthanasia into distinct types (see for example Diaconescu, 2012, p. 475):

1. <u>Active</u> vs <u>Passive</u> euthanasia;
    a. <u>Active</u> euthanasia involves the use of lethal substance or force to end a life that would not otherwise end of its own condition. For example, lethal injection of a paralytic substance to paralyze a person's lungs and heart, when the lungs would otherwise continue breathing on their own and the heart would otherwise continue beating on its own. Most major world religions assess this as impermissible. [7]
    b. <u>Passive</u> euthanasia refers to the withholding or withdrawal of treatment necessary for continued life, thereby 'passively' allowing the person to die from an underlying condition once external supports are removed. For example, "pulling the plug" on a heart-lung machine that is artificially prolonging life. In more controversial cases that go beyond withdrawal of such so-called 'extraordinary' supports, passive euthanasia might involve withholding the sort of 'ordinary' support needed for continued life, i.e. the

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[7] See for example Pew Research Center, 2013. Examples of religions that assess active euthanasia as morally impermissible while assessing passive euthanasia as morally permissible (typically drawing the distinction between 'active killing' and 'allowing death to occur'), include but are not limited to: Judaism, Catholicism (and other Christian denominations such as Eastern Orthodoxy and Lutheranism), Buddhism, Mormonism, and Islam. Certain other religions can be presumed to generally frown on active euthanasia, such as Hinduism (which advocates against all forms of killing and cautions against delaying suffering by trying to avoid it in this life due to risk of karmically worsening it in the next), or the non-theistic religion of Confucianism which generally considers death "unwanted" and actions assisting death as "immoral" (Lee et al., 2015).

nutritional support of food, or water. Most major world religions assess passive measures as at least conditionally permissible.[8]

2. Direct vs Indirect euthanasia (these qualifiers referring to intention);
    a. Direct euthanasia directly and primarily intends death as its result. If the patient were to fail to die, the action would not have achieved its end goal.
    b. Indirect euthanasia directly and primarily intends some purpose other than causing death, but nonetheless also causes death as a 'double effect.' If the patient were to fail to die, this could be a welcomed outcome. For example, the administration of palliative doses of pain medication, for the direct and primary intention of relieving pain, that in the dose necessary to effectively alleviate pain, could lead to that patient's death. The necessary pain-relieving dose may even be foreseeably *likely* to lead to death, but so long as this would be an unintended side effect of the pain-relieving action, and the patient's unexpected continued life might be greeted with surprised gladness, not disappointment, the euthanasia remains indirect.
3. Voluntary vs Non-voluntary vs Involuntary euthanasia.
    a. Voluntary euthanasia is euthanasia performed on a patient who requests euthanasia.
    b. Non-voluntary euthanasia is euthanasia performed on a patient who is unable to provide consent. (E.g. euthanasia performed on an infant or a person in a vegetative state.)
    c. Involuntary euthanasia is euthanasia performed on a person capable of consent but who has not given it, or who has expressed that they do not wish to be euthanized.

Based on these categorical distinctions, then, we can observe that the action requested by Sasha in our opening thought experiment refers to active + direct + voluntary euthanasia. Prior to the

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[8] Ibid.

circumstance-restricted legalization of active + direct + voluntary euthanasia in Canada in 2016, certain other forms of euthanasia had already been legal in Canada, e.g. the passive + voluntary euthanasia of withholding or withdrawing treatment with patient consent, or the indirect euthanasia of providing pain-proportionately necessary pain medication that might foreseeably cause death by double effect. However, these were not (and are not) typically referenced as "euthanasia" in common discourse, with "euthanasia" typically reserved by most speakers only for the traditionally forbidden practice of active + direct euthanasia. Passive or indirect practices are typically referenced instead by plain-language descriptions of whatever they involve: withdrawing treatment, administering palliative sedation, etc. The word "**euthanasia**," then, generally denotes "active + direct euthanasia" rather than other subtypes, and this holds true for use of the word in the Canadian media articles under analysis in this research.

While active + direct + voluntary euthanasia is now legal in Canada under some circumstances, Canada still prohibits active + direct + non-voluntary or involuntary euthanasia. (For a visual aid illustrating the Canadian legal status of euthanasia subcategories, see Figure 1 on page 18.) However, subsequent to the initial restricted scope of legalization in Canada, arguments have been put forward in Canada to expand the procedure to non-voluntary euthanasia, such as actively and directly euthanizing infants or people in comas. There is at least one country where active + non-voluntary euthanasia is already an institutionally permitted practice[9], as well as several countries where passive +

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[9] This country is the Netherlands, regarding the active + direct euthanasia of infants in accordance with what is known as the Groningen Protocol. Euthanasia of an infant is always an example of non-voluntary euthanasia, because infants are a category of person not capable of consent (though under the Groningen Protocol, active + direct euthanasia is limited to only those infants whose parents consent). The Groningen Protocol, which details the conditions under which an infant may be euthanized, was published in the *New England Journal of Medicine* in 2005 and endorsed by the Dutch Pediatric Association. While active + direct euthanasia of minors under 12 years of age is technically not protected by Dutch euthanasia legislation (which stipulates only that a

non-voluntary euthanasia is legal[10]. Finally, the Canadian law permitting active + direct + voluntary euthanasia simultaneously (and interchangeably) permits what is known as ‘physician assisted suicide’, which is usually recognized as distinct from euthanasia in the laws of other countries (if not in the popular imagination). See next definition.

Physician Assisted Suicide (PAS)

Physician Assisted Suicide (PAS) is the phrase and acronym often used in academic literature to refer to a patient deliberately self-administering a known lethal substance, which has been prescribed to them or provided to them by a physician for that purpose. The distinguishing feature of Physician Assisted Suicide is that the patient technically performs the final lethal action themselves, with, for example, the patient drinking from a cup, rather than the physician pushing in a syringe. Some argue that the distinction between these two acts must be conceptually maintained (e.g.

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doctor is protected from prosecution if a patient is 12 years or older, requiring parental consent if between 12-16), “in the Dutch legal system, judicial decisions are based primarily on the medical profession’s opinion if detailed formal legislation is absent” (Verhagen, 2014, p. 298), and the Dutch public prosecutor abstains from prosecuting the active + direct euthanasia of infants so long as the Groningen Protocol is followed.

[10] Subject to variable conditions, these jurisdictions include: Albania, Belgium, Czech Republic, Denmark, Finland, Georgia, Germany, Hungary, Latvia, Malta, Portugal, Romania, Spain, Switzerland, Turkey, the United States (certain states), and the United Kingdom (Council of Europe, 2003, p. 38). The United Kingdom (UK), notably, has made global headlines in recent years for insisting upon the passive + non-voluntary euthanasia of infants whose parents object, to the point of juridically preventing those parents from transferring their children to healthcare sites in other countries. Most famous have been the media-publicized cases of Charlie Gard, Alfie Evans, and Alta Fixsler, in which foreign government officials, charities, and world religious leaders attempted to intervene on behalf of the parents with offers to transport the children to continued healthcare provision outside the UK at no cost to the UK (offers which UK courts prevented the parents from accepting). The most recent case of Alta Fixsler involved a Hassidic Jewish family with no UK citizenship, whose daughter was nonetheless refused discharge from a UK hospital for either independently funded home care or treatment in one of her parents’ countries of citizenship. The UK court interpreted that death, rather than continued healthcare in America or Israel, was in the child’s “best interests” (Guttentag, 2021).

Diaconescu, 2012), and countries today typically draw legal distinctions between the acts (sometimes legalizing only one or the other, and if legalizing both specifying both).

At the same time, many seem to consider Physician Assisted Suicide so essentially equivalent to <u>active + direct + voluntary</u> euthanasia that the terms 'physician assisted suicide' and 'euthanasia' are often used interchangeably in both academic literature (e.g. Kuhse, 1997) and in colloquial speech. A given speaker may not even be aware that these terms have philosophically or legally distinct meanings, and context clues may be necessary for the reader to determine the actual practice the speaker intends to reference. The reader will therefore observe the terms 'euthanasia' and 'physician assisted suicide' treated interchangeably in the media narratives under analysis, though may also notice occasions when distinctions between these practices are clearly recognized.

Medical Assistance in Dying (MAID)

Medical Assistance in Dying (MAID) is the signifier used by Canadian law and government (contemporary as of 2021) to signify either of the practices (<u>active + direct + voluntary</u> euthanasia, *or* Physician Assisted Suicide) that have been legalized and are currently regulated in Canada. MAID does not refer to <u>passive</u> or <u>indirect</u> euthanasia, nor to still-criminalized performances of <u>active + direct + voluntary</u> euthanasia that might take place outside of the regulated institutional context of MAID, such as injections administered by non-physicians, or administered in circumstances not qualifying under the law. Use of the phrase 'Medical Assistance in Dying' precedes legalization of the practice to which it refers, and can be observed to have developed in the discourse promoting legalization by reframing perceptions of practices. The development of this signifier can be tracked across media narratives across time, as the signifying language shifted with public opinion from "assisted suicide" to the less stigmatized "assisted dying," with the increased use of medicalizing language recognizable as a conceptual reframing technique. The phrase first appeared in a legal framework in Quebec's 2014

Bill 52, an Act respecting end-of-life-care. See Figure 2 (p. 19) for a detailed description of the two practices to which the 'MAID' refers in the Canadian context.

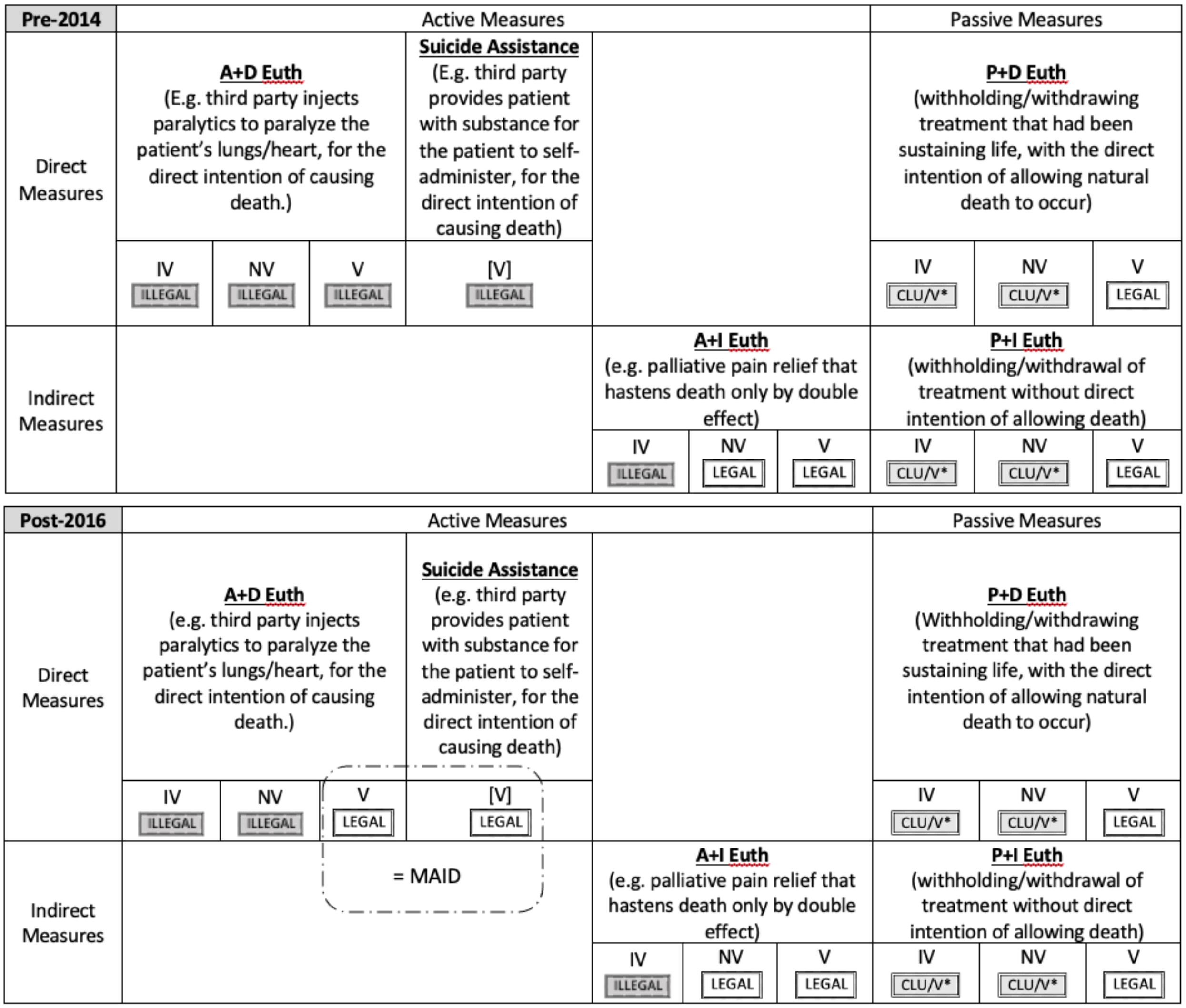
Is there a narrative-camp-neutral signifier for the practice itself?

Given that this research involved analyzing signifying narratives *about* this signified practice, and given that one contested issue between narrative camps was the language used to signify this practice, attempting to identify a signifier which could be considered 'neutral' by all parties was a challenge. On the one hand, 'euthanasia' and 'assisted suicide' are often considered biasing and stigmatizing terms by those who approve of the signified practice, noting historical connotations of criminality or mental illness associated with these terms. On the other hand, 'Medical Assistance in Dying' is often considered a biasing and euphemistic term by those who disapprove of the signified practice, noting that the term presupposes that killing can be medicine, and that the four-word-phrase might be so imprecise as to confuse an uninformed audience about the nature or degree of 'assistance' involved and the immediacy of the death 'assisted'. Indeed, 38-66% of Canadians have been shown to fail to recognize distinctions between end-of-life 'assistance' choices when surveyed, and Canadians who misunderstood such distinctions were found to be more likely to express support for legalization of the signified practice (Marcoux, Mishara, and Durand, 2007). Since Canadian survey support historically became part of the legislative argument for legalization, I appreciate the importance of clear terminology and the reasons why narrators from both 'sides' may consider use of the other side's language a complicit reproduction of (and implicit endorsement of) the ideas that underly the other's use of words.

At the same time, I have not identified a signifier that seems mutually agreeable to the parties that fundamentally disagree over the ethics of this practice, and I am reluctant to insert yet new terms into the conversation by inventing my own terminology. So while acknowledging the above concerns, and not intending this research, by design, to endorse or participate as an entrenched advocate in either of the polarized narratives this research examines, I will vary terminology as seems appropriate in the relevant chapter or context. When referring to the procedure as particular to the Canadian context, I will typically use the Canadian government-legal signifier MAID (except when referring to a precise historical/legal fact, such as the decriminalization of "assisting suicide" from the Criminal Code). I hope my choice to use the acronym rather than four-word phrase will help reduce concerns that my research unnecessarily reproduces the camp-specific belief that <u>active + direct</u> euthanasia can be 'medicine,' or reproduces the misleading impression that dying is always already underway, particularly given that MAID law in Canada has already moved past requiring that an individual be near death to qualify. When academic literature uses the language of 'Physician-Assisted Suicide', 'euthanasia', or even 'killing', I will at times use these terms too, endeavouring to let one piece of literature 'speak' questioningly to, or challenge the assumptions of, another.

Figure 1

Legal Status of Life-ending Actions in Canada, Before 2014 and After 2016



Pre-2014	Active Measures							Passive Measures		
Direct Measures	**A+D Euth** (E.g. third party injects paralytics to paralyze the patient's lungs/heart, for the direct intention of causing death.)			**Suicide Assistance** (E.g. third party provides patient with substance for the patient to self-administer, for the direct intention of causing death)				**P+D Euth** (withholding/withdrawing treatment that had been sustaining life, with the direct intention of allowing natural death to occur)		
	IV ILLEGAL	NV ILLEGAL	V ILLEGAL	[V] ILLEGAL				IV CLU/V*	NV CLU/V*	V LEGAL
Indirect Measures					**A+I Euth** (e.g. palliative pain relief that hastens death only by double effect)			**P+I Euth** (withholding/withdrawal of treatment without direct intention of allowing death)		
					IV ILLEGAL	NV LEGAL	V LEGAL	IV CLU/V*	NV CLU/V*	V LEGAL

Post-2016	Active Measures							Passive Measures		
Direct Measures	**A+D Euth** (e.g. third party injects paralytics to paralyze the patient's lungs/heart, for the direct intention of causing death.)			**Suicide Assistance** (e.g. third party provides patient with substance for the patient to self-administer, for the direct intention of causing death)				**P+D Euth** (Withholding/withdrawing treatment that had been sustaining life, with the direct intention of allowing natural death to occur)		
	IV ILLEGAL	NV ILLEGAL	V LEGAL	[V] LEGAL				IV CLU/V*	NV CLU/V*	V LEGAL
Indirect Measures			= MAID		**A+I Euth** (e.g. palliative pain relief that hastens death only by double effect)			**P+I Euth** (withholding/withdrawal of treatment without direct intention of allowing death)		
					IV ILLEGAL	NV LEGAL	V LEGAL	IV CLU/V*	NV CLU/V*	V LEGAL

Note. Here 'IV' denotes 'Involuntary', 'NV' denotes 'Non-voluntary', and 'V' denotes 'Voluntary'. Both before 2014 and after 2016, patients could legally refuse treatment (including treatment refusal for the direct intention of allowing natural death to occur), and to consent to active measures (e.g. palliative pain relief) that may have a side effect of hastening death so long as the primary and direct purpose of the active measure was not to cause death. The change was legalization of active measures that directly cause death as their primary purpose, in voluntary cases (subject to regulated conditions). *CLU/V denotes 'Case Law Unclear/Varies'. It is currently unclear whether doctors in Canada may withhold or withdraw treatment without the consent of the patient or the patient's substitute decision-maker. Different courts have arrived at different conclusions, and individual conflicts are currently refereed by courts on a case-by-case basis. Ontario, unique among provinces, has province-specific law as of 2019 which permits doctors to withhold one specific treatment (CPR) without requiring prior patient consent, including to the point of overruling the instruction of a substitute decision-maker that CPR be administered. (End-of-Life Law and Policy in Canada, n.d.)

Figure 2

Medical Assistance in Dying (MAID) as a Specific Pair of Procedures Practiced in Canada

Medical Assistance in Dying (MAID)

Intravenous Protocol (active direct euthanasia)

Performed by a third party, under current law a licenced healthcare professional, who administers a sequence of 4-5 drugs by intravenous push doses (interspersed by saline flushing) for the purpose of directly causing the individual's death. "If possible," the infusion needle is inserted "one day in advance."[10] Then at the time of MAID, the following injections are administered: Midazolam (to induce sleep);

- Lidocaine ("to reduce possible burning in a peripheral vein due to Propofol")[11];
- Propofol (an anaesthetic to induce a coma); then
- Rocuronium (a neuromuscular blocking agent to paralyze the diaphragm for fatal respiratory arrest);
- an optional fifth drug, Bupivicaine, is recommended to induce cardiac arrest if cardiac arrest doesn't automatically follow respiratory paralysis within 5 minutes.[12]

Midazolam, propofol, and rocuronium are each associated with pain on injection.[11] However, evidence supports the reduction of pain from propofol injection if lidocaine precedes propofol.[10, 11] Nonetheless, a B.C. MAID protocol guide notes: "Administration of lidocaine beforehand does not guarantee pain-free administration of propofol. It is therefore important that the patient and the other people present are informed that the patient may feel pain during the administration of the propofol" (p. 17).[10]

Death usually results within ten minutes of administering the intravenous protocol.

Between June 2016 to June 2017 (the first year in which MAID was legal in Canada), the vast majority of Canadian MAID deaths (1,977 out of 1,982, or 99.75%) were administered intravenously by active direct euthanasia.[13]

Oral Protocol (assisted suicide)

This consists of oral self-administration of a liquid 'MCP' mixture provided to the individual by, under current law, a licenced healthcare professional, for the purpose of directly causing the individual's death. 'MCP' includes:

- Morphine (at an overdose level 30x higher than the maximum prescribed for pain relief; likely to lead to fatal CNS depression and respiratory arrest);
- Chloral Hydrate (a hypnotic for sedation), and
- Phenobarbital (a hypnotic and anti-convulsant, at an overdose level 2-10x higher than the usual level at which fatal respiratory arrest becomes likely).

This procedure involves the individual:

- fasting (except for water or juice) for 4-5 hours prior;
- receiving Metoclopramide and Ondansetron (to prevent nausea and vomiting) one hour prior to the protocol;
- at the time of protocol, being given the liquid MCP compound (120 mL) to be consumed within 4 minutes to avoid falling asleep before finishing consumption.

The individual is to be advised in advance that the mixture tastes bitter. In rare cases, vomiting occurs after taking the treatment; the attending professional is to administer Haloperidol if the individual experiences significant nausea, and to continue to stand by in case the oral protocol is unsuccessful and intravenous protocol is required.[10]

The individual is expected to fall into a deep sleep within 1-10 minutes of consuming MCP, and to die within 30 minutes, although it may be up to 24 hours before death unless the physician pre-arranged with the patient to administer a backup intravenous protocol after a pre-arranged timeframe. While sleeping and before death, expectations may be set to anticipate that individuals "may have loud snoring, gurgling, hiccups, irregular breathing and pale cool skin."[10]

Between June 2016 and June 2017, only five out of 1,982 MAID deaths (0.25%) were by oral protocol.[12]

Note. Variations occur across regions and time. This sample summary is offered by way of example only.

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[11] Medical Assistance in Dying (MAID): Protocols and Procedures Handbook Comox Valley 2016.

[12] Intravenous Medical Assistance in Dying Medication Protocols in Canada Review and Recommendations. A Canadian Association of Medical Assistance in Dying Assessors and Providers (CAMAP) White Paper on Intravenous Medical Assistance in Dying (April 2020).

[13] Bryden, 2017.

Chapter 2: Literature Review

For the purpose of supporting the later analysis of Canadian media articles on the topic of MAID, I chose to review academic literature exploring themes that had emerged from a preliminary review of 15 purposively sampled media articles (those articles identified in the *Initial Scoping Review,* pp. 41-42). While there is a larger stream of legal and ethical literature on the topic of MAID, I chose to engage primarily with literature specifically relevant to trends and themes emergent from Canadian news media narratives, especially favouring inclusion of sociological literature. In the final revision of this research, retaining only those themes most relevant to later analysis, these themes could be summarized as: (1) the content of typical advocacy arguments; (2) the relationship between religion and PAS attitudes; (3) the relationship between individualism and PAS attitudes; (4) modern deathways as structured by rational bureaucratization; (5) vulnerability ethics and biomedical personhood discourses; and (6) capital relations as intersectional with biopolitical developments.

To begin by allowing the voices of competing advocates to speak for themselves, the arguments of contemporary proponents and opponents of suicide assistance or <u>active + direct</u> euthanasia can be summarized as follows:

Proponents of suicide assistance or <u>active + direct</u> euthanasia:

- May consider it a "humane solution to unbearable suffering and a way to die with dignity" (Verbakel & Jaspers, 2010; see also Walter, 2012);
- May view it as part of a normative values system that asserts and prioritizes an individual's right to self-determination (Verbakel & Jaspers, 2010; Titterington et al., 2013).

Opponents of suicide assistance or <u>active + direct</u> euthanasia:

- May object for religious reasons, whether grounded in Eastern or Western religious traditions (Verbakel & Jaspers, 2010; Lee, Jung & Sumner, 2015);
- May be concerned about the risk of abuse when a person is dependent on medical staff or family members to make decisions, or when a person is vulnerable to the sense that their carers wish them dead (Verbakel & Jaspers, 2010; Richards, 2017);
- May be concerned about the risk of an eventual slippery slope to "involuntary euthanasia for persons deemed no longer valuable to society" (Verbakel & Jaspers, 2010).

Understanding the reasoning articulated by proponents/opponents themselves is valuable. At the same time, it is also of interest to examine underlying factors associated with the individuals making the arguments, or the cultural movements within which they experience their scope of possible thought and action. I will begin this review by assessing literature regarding euthanasia attitudes and religion, due to media-revealed assumptions that religion is a key factor shaping euthanasia attitudes.

As already identified under Terminology, most major world religions consider active euthanasia a wrongful act, though many of these same religions accept passive euthanasia, such as withdrawal of treatment to allow natural death while providing comfort care. At the same time, a distinction must be noted between the formal teachings of a religion and the level of adherence to those teachings by members of the religion or those loosely affiliated with it. Verbakel and Jaspers (2010), for example, found from their multilevel analysis of data from thirty-three countries that opposition to euthanasia is indeed more prominent among people who are religious or who live in a religious context. They found Muslims the most opposed, followed "at some distance" by Catholics and then Protestants, and found 'religiosity'—that is, the importance of religion in a person's life—a stronger predictor of euthanasia opposition than the religious denomination (2010, p. 124). Titterington et al. (2013) found similarly that overall, religiously practicing individuals were more likely to reject euthanasia than were non-practicing religious or nonreligious individuals.

But parsing denominational information with more precision, Hamil-Luker & Smith (1998) noted that there were sometimes significant and surprising differences in euthanasia attitudes among individual members of Judeo-Christian denominations that didn't correspond to the formal teachings of the religious authorities of those denominations. These authors found that when surveying those who lived in a secular culture, Catholic and fundamentalist Protestant individuals were actually "not statistically different from the non-religious in their euthanasia attitudes" (Hamil-Luker & Smith, 1998, p. 384). In fact, the only surveyed groups that significantly differed from the nonreligious in euthanasia attitude were 'Liberal Protestants' and 'Evangelical Protestants.' Liberal Protestants were actually *more than twice* as likely to support euthanasia than were nonreligious people[14], and Evangelical Protestants were *less than half* as likely to support euthanasia than were nonreligious people. Evangelical Protestants were the only surveyed group of laypeople to oppose euthanasia more than they supported it, a phenomenon that Hamil-Luker and Smith relate to the history of "evangelical affirmations" by which evangelicals remind themselves to remain "distinctive from [the] culture" while engaging it, resulting in increased resistance to trends or pressures from the secular culture around them (Hamil-Luker & Smith, 1998, p. 386).

The seemingly low resistance of religious laypeople to the pro-euthanasia values of secular culture was also noted, with surprise, by Verbakel and Jaspers (2010). These authors found that differences in levels of approval between religious and nonreligious individuals were larger in religious countries than in secular countries. In other words, and contrary to what they expected, these analysts found that differences of opinion were "more strongly expressed in devout societies than in secular societies" (2010, p. 133). This data suggested that "nonreligious adhere especially strong[ly] to their liberal values concerning euthanasia" – more so than religious adhere to their religious values requiring opposition to euthanasia. Verbakel and Jaspers suggest that

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[14] This finding is particularly relevant to the Canadian context due to Canadian religious demographics. The most up-to-date survey, conducted by the Pew Research Center in 2018, reports Canadians self-identifying as 29% Catholic, 29% atheist/agnostic/unaffiliated, and 18% Protestant (Lipka, 2019). The most-populated Protestant denomination in Canada is the United Church of Canada (at 6.1% of Canadians according to Statistics Canada, 2013), which in 2017 issued a formal statement declaring itself "not opposed in principle" to active + direct euthanasia (The United Church of Canada, 2017). The United Church did later issue a revised statement advocating that "foreseeable death" remain a criterion, and that the practice not be expanded to the mentally ill or permitted by advance directives, but continued to support the legality of this practice at baseline, as well as formally indicating support for extending this practice to minors on a case-by-case basis (The United Church of Canada, 2020).

> [Perhaps] secular societies push the attitudes of religious persons toward acceptance of more liberal perspectives, whereas devout societies reinforce the beliefs of their religious inhabitants… however, this line of thought assumes that religious persons are sensitive to their environment, whereas nonreligious persons are not, or to a lesser extent (2010, p. 133).

Verbakel and Jaspers ultimately acknowledged having "no explanation" for this unexpected result, and proposed further research into the question of religious sensitivity to secularization values, as contrasted with nonreligious resistance to religious values. This finding is relevant to any analysis of religious laypeople interacting with euthanasia discourses, given increasing rates of secularization across the Western world, though secularization levels and processes vary enormously between countries (Walter, 2012). Proulx and Savage (2020) note that across twentieth century Europe, church memberships have been declining, including steep declines in Dutch church memberships since the 1960s. For those who have retained church memberships, modernization as well as the Second Vatican Council has led to "more relaxed institutional views on the separation of Catholics and Protestants," and some liberal Protestant churches have even become supportive of euthanasia (Proulx & Savage, 2020, p. 1120; see also Titterington et al., 2013). Even the historically Catholic Poland is showing increased "depart[ure] from institutional religiosity", especially among young males in bigger cities, with young females increasingly following this male-led pattern. Weekly mass attendance has dropped from 55% in 1996 to 32% in 2016 among youth in Poland, and activities such as supermarket shopping are perceived as "more satisfactory forms of activity" than religious worship (Verbakel & Jaspers, 2010, pp. 89-94).

Walter (2012) notes that "in individualistic societies, talk about religion is increasingly being replaced by talk of spirituality" and an ever-more-granular "right to choose" (2012, p. 132). The Protestant discourse of 'denominational choice', which itself replaced the Catholic discourse of submission to one authoritative Church, has been replaced by a discourse of individualized spiritual choices in which the individual uses "whatever ideas, beliefs and practices feel right to the individual, and the authority of religious institutions, especially those of the world religions, is distrusted" (Walter, 2012, p. 132). This impacts end-of-life care in more individualistic countries by, for example, the rebranding of healthcare chaplaincy as "spiritual care provision" outside the structure of denominational frameworks (Walter, 2012, pp. 132-133).

Consistent with these findings about the heterogeneity of beliefs among those still religiously affiliated, and about the shift from 'religion' to 'spirituality' in individualistic societies, Kemmelmeier, Wieczorkowska, Erb, and Burnstein (2002) examined attitudes toward active euthanasia and suicide assistance cross-culturally and found, consistent with other data already discussed, that "religious traditions differ in their views of this issue; and even within religious traditions, the status of euthanasia is controversial. Further, many opponents of Physician-Assisted Suicide and euthanasia are not religious, thus weakening religiosity as an explanatory concept" (Kemmelmeier et al., 2002, p. 61). These authors rejected not only the 'reducible-to-religion' explanation for opposing euthanasia, but also rejected the liberal/conservative dualistic explanation, and concluded instead that the basis of a person's views on this issue rest on a person's positionality on the individualist/collectivist value spectrum, noting that "terminally ill patients who were concerned about [individualist values such as] the loss of autonomy and control as a result of their illnesses were significantly more likely to request Physician-Assisted Suicide than were patients for whom the loss of autonomy and personal control were less salient" (2002, p. 62). This seems to correspond with the perception of suicide assistance and euthanasia as a "non-issue… in many so-called collectivist societies… [such as] India and China" (Kemmelmeier et al., 2002, pp. 77-78).

This perspective may be supported by the findings of Yaka et al (2014), who found higher rates of depression among elderly individuals in Europe (at 10.9%) and America (8.4%) than in Asia (4.2%), concluding that risk factors for depression in the elderly included perceived economic dependency, perceptions about which could vary according to cultural differences. The theory that individualist attitudes predict support for euthanasia was particularly corroborated by Verbakel and Jaspers (2010), who found that across thirty-three countries, support for euthanasia was more prominent among people with more attachment to personal autonomy or who lived in countries with "stronger than average attachment to autonomy" (Verbakel and Jaspers, 2010, p. 128). Whereas support for euthanasia was higher among those assessed to be "medium and highly educated", as measured by grades or certifications issued by educational institutions, attitudinal differences between those at higher and lower educational levels decreased as the average attachment to autonomy in a country increased (Verbakel and Jaspers, 2010, p. 130).

Lee, Jung and Sumner (2015), examining potential differences between the elderly experience in individualist versus collectivist societies, examined differences in ageist attitudes between Korean versus American young students in social work who might form part of the social support experience of older people. Lee et al found that while the pro-individualist influence of western cultures was affecting traditionally collectivist Asian norms among the younger generation of Asians, there remained a difference between ageist attitudes of Koreans and Americans (2015). To test differences of ageist attitudes between social work students of these countries, Lee et al used questionnaires based on a hypothetical case of a client with cancer considering suicide –in some cases describing the client being 80 years old, and in others 38 years old, all other factors held constant. While both groups of social work students surveyed were more likely to hold "negative beliefs" about the 80-year-old client compared to the 38-year-old client, perceiving the 80-year-old as more in need of preparation for death, there were significant differences in the ageist attitudes they held. Korean students were more likely to consider their patient "confused and unable to make her own choices," in need of psychotherapy, and disagreed that an 80-year-old client had "lived a long life". Korean students were also more likely to say they "want to help" the 80-year-old client. In contrast, American students were more likely to believe their 80-year-old client had lived a long life, would most likely "die regardless of medical care," and "should be allowed to commit suicide," including by legalizing physician-assisted suicide for her case, with American students more supportive of assisting the suicide of an 80-year-old than of a 38-year-old.

Lee et al suggested that the attitudes of the Korean students were rooted in cultural Confucian values that emphasize filial piety. They noted significant differences in aging stereotypes, with Asian negative stereotypes more physically straightforward ("older adults must have hearing and memory problems"), and American negative stereotypes more extensive and socially judgmental ("older adults [are] unproductive, weak, senile, depressing, lonely, poor, cognitively impaired, sexless, dependent, and disabled"). The authors noted that these American stereotypes could "lead to social isolation, inadequate mental and physical treatment, and suicide" of older people (Lee et al., 2015), and expressed concern that with younger Asians increasingly living apart from older adults, "ageism has increased in Asian cultures," though so far Asian older people still "have [high] expectations for filial piety" (Lee et al., 2015). Lee et al. argued that Confucianism must be "preserved and nurtured through education and social norm", to guard against "westernizing influence" and prevent the increasing danger of Western-style ageism that increases the risk of "radical human rights problems that many older people would face" (Lee et al., 2015).

Regarding potential problems faced by the elderly, Walter (2012) notes that modern deathways are shaped by urbanization, technology, and rationalized bureaucratization of systems, and have resulted in a shift of 'typical death' from childhood death by infectious disease, to "slow, elderly dying" from degenerative disease (2012, p. 126). Walter notes that the goals towards which rationalized processes are oriented – "control, progress and happiness" – can seem "threatened" by the uncontrollable fact of eventual death, which thereby becomes "unspeakable", resulting in "modern health and social care systems [which] often segregate and isolate the dying" (Walter, 2012, p. 127). The loss of felt-personhood in such systems is, Walter suggests, "arguably what motivates the death awareness movement to create more humane ways of dying and grieving" (Walter, 2012, p. 127).

Reinforcing Walter's case for concern about the bureaucratic rationalization of healthcare are longstanding academic critiques about rationalized bureaucracy in general. While recognizing the positive potentials of rationalized bureaucratic systems, for instance in accelerating and maximizing profit, rationalized bureaucratization has long been critiqued by sociological theorists, from Max Weber (1864-1920) to George Ritzer (1940-present). Weber saw the bureaucratic rationalization of structures and institutions as – far from a 'natural' social phenomenon to be taken for granted – a historically aberrant form of structural "domination" which builds "iron cages" of increasingly thick bars around the people dependent upon and attempting to live and work within these rigid constraints (Weber, Gerth, & Mills, 2009). Rationalized structures prioritize efficiency optimization over human differentiation, calculating the "optimum profitability of the individual worker" and "completely" reshaping the "psycho-physical apparatus" of each individual to conform to the "demands of the outer world, the tools, the machines" (Weber, Gerth, & Mills, 2009, pp. 261-262). Ritzer notes that Weber – while critical of certain capitalist phenomena – expressed appreciation that a capitalist society at least allowed for the possibility of a worker's escape (albeit at cost) into 'gaps' between the iron cages scattered throughout society, in contrast to what Weber viewed as the totalizing danger of socialism, insofar as socialism's goal was "the creation of an overarching rational system, a truly "gapless" iron cage at the societal level" (Ritzer, 2003, p. 121).

In the context of Canada's public health system, Weber's concern about economic dependence upon one overarching rational system would seem to raise questions about how Canada's individual health workers can live out their differentiated human realities within the rationally bureaucratized "iron cage" of one single, totalizing health system which sets licencing requirements and metes out financial compensation.[15] Beyond the potential concerns of dependent ('caged') workers, Ritzer's

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[15] For example, consider the differences of ethical commitments, emotional experience, and community concept of a practicing Orthodox Jew (religiously committed to refusing participation in the assistance of

thesis about the McDonaldization of Society[16] considers also the experience of consumers of the products of rationalized institutions, noting that trends toward De-McDonaldization seem already underway in various contexts, as consumers 'quietly rebel' against the rationalized/McDonaldized homogenization and regionally non-distinct mass production of goods and services. Such social movements against McDonaldization include attempts to support a "New Regionalism," deliberately sacrificing McDonaldized values, such as widespread delivery of uniform products and services, to prioritize other values and produce higher quality (or regionally unique and preferred) goods or services in smaller amounts (Ritzer, 1998).

One might see such resistance to McDonaldization in the efforts of early euthanasia proponents who, Walter noted, may have been partly motivated to address rationalized deathways experienced as impersonally cold and unsatisfying (Walter, 2012). One might also see such resistance in the efforts of euthanasia's opponents who advocate for preserving regional differentiation between healthcare sites, enabling 'safe spaces' where health workers may be free from pressure to participate in active euthanasia or referral, and where consumers (patients/residents) may be free from concern that active euthanasia may occur in their care home or might be considered by their attendant health worker (see Findings for examples of such concerns).

Diaconescu (2012) seems to agree that changes in modern deathways (especially rationalized systems and technology) have contributed to a wider spectrum of questions about the euthanasia issue.

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suicide) in contrast with an atheistic humanist who may support assisting suicide as an ethically laudatory reduction in net material suffering. Can one overarching, bureaucratically rationalized healthcare system make space for such health workers to retain and manifest their differentiated human individuality? If this can be done in theory – will it be done in practice? What practical mechanisms might protect – or inhibit – this freedom to be differentiated?

[16] That is, the ways in which society is increasingly dominated by homogenizing forces rooted in the prioritization of efficiency, calculability, standardization and control.

He notes that medical technologies can keep alive patients who "one or two decades ago would have been dead because these means did not exist at the time," leading to questions about whether a physician should always do what is possible to save a patient's life if the result may only prolong life for a short time, or whether active treatment must always be applied to newborns with "extremely serious malformations" (Diaconescu, 2012, p. 478). While there has traditionally been a clear legal distinction between the widely legal act of passive voluntary euthanasia and the widely prohibited act of active voluntary euthanasia (Verbakel & Jaspers, 2010, p. 110), this distinction is not always recognized by the wider population or even by certain academics. For example, certain 'right-to-die' advocates argue that non-impulsive "old age rational suicide" should be societally accepted as an "understandable" and non-tragic alternative to the "real tragedy" of "extraordinary and invasive measures" taken to extend life in hospital, or being in a care home "without the requisite pain relief" (Richards, 2017). Implicitly, this particular formulation of the argument seems to suggest that an individual must choose between one or the other – suicide or invasive life-extension; suicide or inadequate pain relief – with no third or fourth option available.

Advocates of old age rational suicide (as presented by Richards, 2007) propose that suicidal ideation should not necessarily be pathologized as abnormal, asserting that certain "motivating factor[s]" cannot be "remedied," including the feeling that one's biography is complete; the desire to "celebrate a good life followed by a good death and reject a life lived without pleasure in the specter of a future "bad death";" the fear of "[losing] independence resulting from declining physical and cognitive health"; and a general desire to die in a way that "corresponds to the embodied values by which we have lived our lives" (Richards, 2017). Richards notes that in many regions globally, suicide rates are higher for those over 70 than for other age groups, and there is no consensus as to why – though he concurs that the "not always tragic" motives behind "old age rational suicide" may be intermixed with other more standard suicide drivers such as "chronic illness, functional disability, and social isolation" which can "become more acute in later life" (Richards, 2017).

As Walter notes, the rationalization of healthcare has been "mixed" in the extent to which it is "applied to slow elderly dying," with services poorly organized and inequitably accessible, particularly for stigmatized frail elderly and those with dementia who find themselves "exposed to death" with less protection than other populations receive (Walter, 2012). Such inequities of access to care services may account for the typical trend of higher support for euthanasia among younger people (e.g., Hamil-Luker and Smith, 1998; Verbakel and Jaspers, 2010, p. 124). Similar patterns of euthanasia support correlating to the relative felt-strength of the supporter emerge internationally. Opposition to euthanasia is higher among the socially inactive than among the socially active, and higher among those who "feel little control over the way their lives turn out" in general (Verbakel and Jaspers, 2010).

In the USA at least 20 years ago, "blacks" opposed euthanasia at higher rates than did "whites" (Hamil-Luker and Smith, 1998). Westwood (2017), reflecting on her 'right-to-die' topical interviews with older lesbians and gay men – who often anticipating aging without informal caregivers such as a spouse or children – concluded that there is a need to distinguish between "denial of access to assisted dying, which some may understand as their embodied, autonomous choice" and the vulnerability of some to "ending lives because of insufficient informal care and support and deficiencies in the formal older age care system" (Westwood, 2017, p. 624). Verbakel and Jaspers (2010) found that people who lived in countries with "low-responsive health care systems," regarded by them as untrustworthy to be responsive to peoples' needs, registered stronger opposition to euthanasia legalization overall. They also found the differences in euthanasia-permissiveness attitudes between younger versus older people, and between socially active versus inactive people, were smaller in countries with responsive health care systems. Verbakel and Jaspers concluded that "responsive health care systems appear to be able to neutralize the fear that euthanasia will be abused" (2010, p. 130). Nonetheless, "controversy has remained intense" (Hurst & Mauron, 2003), and vulnerability-based concerns about euthanasia remain prominent among academics and opponents of euthanasia worldwide.

Judith Butler and Anna Szörényi offer insights into an ethic of vulnerability and the reality of unevenly distributed precarities across various contexts – a theoretical lens which these authors do not apply to euthanasia but which does seem suitable. As Szörényi writes, precarity is related to the "underlying problem of inadequate access to a viable life" (2014, p. 33). Butler distinguishes this precarity as distributed between lives that are considered "grievable" versus those that are

> not quite lives, not quite valuable, recognizable, or, indeed, mournable… their lives are not considered to be lives in any full and meaningful sense…. They are themselves living populations with whom cohabitation presupposes a certain interdependency among us. How that interdependency is avowed (or disavowed) and instituted (or not) has concrete implications for who survives, who thrives, who barely makes it, and who is eliminated or left to die. (Butler, 2009, pp. 42-43)

While Butler speaks here of wars and victims of war, one might imagine she had been directly speaking into the euthanasia debate, in a voice that would surely resonate with those who express concern about potential consequences of legalized euthanasia. After all, euthanasia's opponents might argue, which lives are considered less "full and meaningful" in our culture than disabled or demented lives? Whose cohabitation with us involves the highest levels of dependence? Surely children, the elderly, and the sick or disabled—the populations for whom suicide assistance or active + direct euthanasia are typically legitimized by the state. In this modern era when – as the jocular saying goes –many of us see ourselves no longer as human beings but as human doings, human beings become no longer grievable. Instead, under individualist value systems highly attached to autonomy, it is human 'doings' which are grievable. That is, persons become meaningfully identifiable as 'persons' and possess a (lose-able) dignity based on their capacity to 'do', not based on an inherent dignity of 'being.' The 'able' are grievable, whereas the non-able, the dis-abled (of whatever category) are non-grievable.

Butler herself identifies the implications of rethinking the reproduction of 'able-ist' bodily norms and newly perceiving the 'human form' as inclusive of disabled bodies (Butler, 2009, p. 52). This ethos is echoed also by Woodcock (2009) who argues more strongly that it is morally obligatory to preserve a diversity of human 'kinds' – including those human 'kinds' considered disabled by one kind while nonetheless recognizing each other as "agents deserving of equal respect and moral standing" (Woodcock, 2009). Woodcock argues that society should acknowledge its obligation to not only preserve this diversity of human kinds but also to actively "value the contribution of those members of the moral community with unique points of view" (Woodcock, 2009, para. 48). Woodcock's argument extends beyond euthanasia to also oppose eugenics, arguing that preventing the births of different human kinds – with possible but bounded exceptions – is morally wrong.

However, the inclusivity goals of academics such as Butler and Woodcock face challenges of implementation. Nikolas Rose, in his 2013 work, 'The Human Sciences in a biological Age', highlights one such challenge to the inclusivity of disabled bodies and the reaffirmation of traditional conceptions of universal human dignity: the challenge of contemporary biomedical and psy-science discourses of 'personhood'.

> Not just in 'the West' but also in many other regions, individuals are coming to understand themselves in the language of contemporary biomedicine, to judge themselves in terms of the norms articulated by biomedical experts, to modulate their bodies and minds with products that are the product of biomedical belief systems, to use new reproductive technologies to manage procreation, to consider replacing worn out body parts with artificial hips and knees, to think about reducing risks of disease with diet and exercise, and to worry, individually and collectively, about Alzheimer's and the dementias, maybe even to take up Sudoku and mind gyms in the belief that if they act this way, they may be saved. In this sense, personhood itself is becoming increasingly somatic. (Rose, 2013, p. 6)

Examples of this sense of the non-salvageable 'bad life' (to use Butler's term) or non-personhood of humans with biomedically worn out bodies and dementia can be seen in contemporary Canadian media (other examples will appear throughout the 'Findings' section):

> He's seen men like himself hunched over in chairs in long-term-care centres, their minds absent, unaware there hasn't been a visitor for years. . . . "It struck me: why should he be like this? Why

> not just finish it? He's just a vegetable," Bakshi said to her. "'You mean kill my husband? I can't kill him,'" she responded. "Nobody should be in that situation," Bakshi says, his cheeks apple-flushed, his sharp eyes framed with straying silver eyebrows and wirerimmed bifocals. (Sinnema, 2012)
>
> At 78 and suffering from a list of health problems, including an incurable lung condition, idiopathic pulmonary fibrosis, that was making it increasingly difficult to breathe, there was no going back to health; only forward to death… Last Friday night… Marcel Tremblay suffocated himself. Tremblay made a difficult, but nevertheless rational and informed, choice to end his life. ("A compassionate death," 2005)

These quotes illustrate how biomedical discourses cultivate the psy-science notion of personhood such that once the mind is "lost" to dementia, or the physical body has "incurable" biomedical health problems, there is perceived to be "no going back… only forward to death". The 'rational' actor recognizes this deterioration and engages in self-governance and self-management processes (e.g. Sudoku, diet and exercise – or self-killing) while they still have a biomedically meaningful 'self', to either cure their biomedical condition or accelerate the biomedically inevitable.

Critiques of biomedical discourses are often expressed with particular poignancy by persons who themselves experience disability and speak with insight about the subtle ways in which social discourses can impact them. Such disability advocates problematize the biomedical implications behind "quality of life" discourses, and note the impact these discourses can have, directly and indirectly, especially on persons who already have disabilities. In another news excerpt, the co-chair of the Manitoba League of Persons with Disabilities noted in 2016, reacting to a news story in which a Winnipeg man sought euthanasia after losing the ability to walk:

> [This] reflects a "bleak" societal attitude: "He would rather be dead than disabled…. For me it's sad that he would rather die than be in a wheelchair… And many people would agree with him." Mankewich noted that even though John's condition is not terminal, his request might be deemed reasonable… because of society's "able-ist" mentality. "Our society equates quality of life with the absence of disability," Mankewich said, adding "if I found the right doctor, I could string them along to believe I need an assisted death." (Carreiro, 2016)

Even Richards (2017), who himself argues in favour of social acceptance for "old age rational suicide", acknowledges this concern of assisted suicide's opponents: that carers, "motivated by the prospect of financial gain or in order to be relieved of the burden of caring", may "encourage (however subtly)" a vulnerable person to "make use of the legislation" (Richards, 2017). Kass (2002) elaborates on the fear that, after a global values shift corresponding with legalization of assisted suicide or euthanasia, certain patients will be subtly offered less encouragement or fewer options than they otherwise might be, or will question whether their caregivers wish them dead. This would constitute, Kass suggests, coercive social and psychological pressure related to already deeply entrenched fears of being perceived as a 'burden', precluding the possibility of 'purely voluntary' assisted suicide for many. Drawing on data regarding "do not resuscitate" orders, Kass concludes that doctors may in fact fight less hard to protect the lives of some patients, especially those patients most difficult to cure (2002, p. 29). The salience of these concerns regarding patients' fears of being perceived as a burden, and barriers to equal care options for 'problematic' patients (e.g. dementia patients), were noted also by the 2011 Royal Society of Canada Expert Panel on End-of-Life Decision Making. Disabled author Ruth Enns makes her own critique of biomedical discourses of a 'good life', especially discourses about 'quality of life'. In the following submission to media, she describes how biomedical normativity discourses impact disabled populations by their implications:

> A clue to the double standard[17] lies in the commonly used phrase "quality of life" (QoL). In medical contexts, QoL seems to be code for disability, pain and proximity to death with frequent conflation of these three. People with disabilities regularly encounter misperceptions of their "suffering" and pain. They find others rate their lives and QoL lower than they do themselves… In my book on the Latimer case, I described the late Mike Rosner's experience with his doctors in 1992. Instead of treatment for his treatable pneumonia he was offered "death with dignity." Only with the help of friends was he able to get the treatment he needed and continue with his productive life. When death for those of us with disabilities is termed "dignified" it implies that our lives are not dignified…. In this cultural script of life, legalizing "death with dignity" would strongly imply that if we become burdensome, we become undignified and unworthy. If we want to be worthy, we should bow out. (Enns, 2013)

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[17] Enns here refers to a "double standard" between efforts to prevent copycat suicides, and lack of discourses about preventing copycat assisted suicides.

Butler emphasizes that inequitable distributions of access to livability are always maintained through violence: “indeed, political violence could be defined as the act of exploiting another’s vulnerability in order to bolster one’s own immunity” (Szörényi, 2014, p. 32). Butler (2004) draws a distinction between a linguistic request and the cry of the deepest self for meaningful assistance, when she discusses the Levinasian notion of ‘the face’ in her piece called ‘Precarious Life’. As she writes in that piece, “the “face” does not speak in the sense that the mouth does; the face is neither reducible to the mouth nor, indeed, to anything the mouth has to utter” (Butler, 2004, pp. 132-133). The face, rather, expresses a suffering of the other, that calls us to responsibility in a very specific way: “not to let him die alone, as if to do so were to become an accomplice in his death. Thus [separate from any utterances the mouth may make] the face says to me: you shall not kill” (2004, pp. 131-132). But why might the mouth utter a request that the face may belie? Rose points out that cultures, not mere biomedical factors, shape the “manifestation of distress” and “sense of personhood” of humans. Cognitive characterizations of the meaning-landscape and ‘personhood’ of humans inform the utterances of suicidal ideation which are a manifestation of distress in our culture. As Rose notes:

> One can be brought to death by one’s genuine belief that one has been cursed… The recognition that the habitus, bodily capacities and fundamental mental categories of humans require formation – that the envelope of the skin does not, by rights, delineate an enclosed, autonomous zone – is thus by no means new. The human body cannot be the province of the biologists alone: culture, symbolism and the imagination are also constitutive, even when it comes to the organization and properties of basic musculature, hormonal systems, sicknesses and their cure, its emotional economy and even its passage to death. (Rose, 2013, pp. 13-14)

Who is more ‘cursed’ than the person who genuinely believes they are biomedically doomed to become, as Bakshi lamented, a “vegetable”? And how much more directly can one be brought to death by one’s own belief than by belief bringing us to the point of requesting lethal injection? The emotional economy and passage to death of the contemporary MAID-seeker, especially in an environment of effective pain-management and technological supports to address physiological concerns, must therefore be recognized, the literature suggests, as deeply cultural: not inherent to the biomedical condition of being disabled, elderly, or sick, but occurring within a cultural context shaped by biomedical psy-science personhood discourses in an environment of unevenly distributed precarity.

It seems relevant to note one more facet of the assisted suicide and euthanasia conversation: the impact of economic pressures on state policy, which are relevant in any policy analysis, and the phenomenon of capital relations. Titterington et al. (2013) point out that in most industrialized countries "the costs of health care… are on the rise…. [and] economists predict that this trend is likely to persist, and even speed up, in coming years" (para. 11). Population aging is cited as contributing to these costs, with the demographically more populous baby-boomers relying on relatively fewer tax-paying citizens to fund their use of expensive new health technologies during increased life-expectancies (Titterington et al., 2013; Lee et al., 2015). In their 2013 analysis of 19 industrial democracies, testing for factors associated with the legalization of suicide assistance or euthanasia, Titterington et al. found that, with the exception of Luxembourg, countries adopting 'right-to-die' legislation were countries with a "more economically challenged health care system" relative to the other countries under analysis, as measured by the percentage of a country's GDP spent on health care and the percentage of health care provided by public funds.

The authors had previously hypothesized that 'right-to-die' policies would correlate with the old age dependency ratio, which is the "size of the older population relative to the size of the population that could be expected to pay taxes" (2013, para. 19) But to their surprise, only one of the countries with a right-to-die policy even ranked in the top half of analyzed countries on this measure. Therefore, the authors determined that it was not a disproportionately large population of elderly people that correlated with the enactment of 'right-to-die' policies, but whether a country was already finding health care within its borders economically challenging. As Titterington et al. concluded in 2013:

> We surmise that a large commitment to health care services, at the expense of competing national economic needs, may prompt legislation that enables active termination of life. The premise is that life-enhancing and life-sustaining technologies to provide medical care for the chronically ill, those requiring long-term institutional care, and procedures that keep the dying

> in a vegetative state are expensive… Under the scenario of an aging population there may be financial incentives to allow for the early termination of life." (Titterington et al, 2013, para. 17)

In this light, Hardt and Negri (2009) offer insights into biopolitical developments as intersectional with capital relations. These authors emphasized in their work 'Commonwealth' the enduring insight of Marx that capital is a social relation reproduced by the "production of surplus value via the production of commodities" (Hardt and Negri, 2009, p. 136). Hardt and Negri also drew on Foucault to argue that humankind does not merely reproduce itself in values and products, but draws from existing capacities to potentially destroy itself to create something new and as of yet unknown (2009, p. 136), with the cautionary note that capitalist processes are adaptive to such liberation attempts and will continually seek to co-opt biopolitical developments into the capitalist model. Hardt and Negri's theory of the predatory expropriation of the common can, I suggest, be reasonably incorporated with Rose's framing of the biopolitical shift towards psy-and-body-based personhood discourses to potentially explain the privatization of what Butler or Woodcock might argue should be public wealth property rights. Such 'public wealth property rights' might include cultural value discourses of human dignity and rights to assisted life, or material distribution of goods and services such as hospital beds or care work. Biopolitical discourse shifts may dispossess vulnerable (e.g. elderly or disabled) people of their sense of 'rights to property' in these areas, while recognizing these public wealth property rights as privately belonging only to the young, able-bodied or otherwise psychologically/biomedically 'well'.

Capital relations encourage discourses which promote human self-selection away from 'draining resources', freeing up hospital beds, family free time, and palliative care resources for the less biomedically problematic, without having to expend more capital on additional hospital beds, family caregiving work, or improved palliative care. From the perspective of capital, assisted suicide or euthanasia, resulting in a higher surplus of commodities for those still living, may seem more rational than assisted life, and so one might expect that this 'biomedical personhood' discourse shift will continue to be embraced and co-opted by capitalist processes. After all, if capital is a “production of surplus value via the production of commodities” (Hardt and Negri, 2009, p. 136), then the production of the commodity of ‘death as dignity’ values in populations of disabled and sick people produces the ‘surplus value’ of ‘unburdened’ convenience, comfort, time, and a greater share of material and healthcare resources available to the young, healthy and able-bodied. The public and social wealth of care resources may thereby become privatized to biomedically ‘well’ ‘persons’, while the costs of such a biomedical values system are externalized and the frail and disabled, lacking either psy-defined ‘personhood’ or biomedically defined ‘Quality of Life’, take on the affective and emotional labor of dying to protect the ‘profits’ of those judged to live a biomedically “good life.”

Chapter 3: Methodology

The qualitative narrative policy framework (Q-NPF), developed by Gray and Jones (2016), is the methodology employed in this research to study the contested meaningfulness and social construction of 'Medical Assistance in Dying' (MAID). As a framework for analyzing competing policy narratives, the Q-NPF principles and techniques have shaped the overall form of this research.

The Qualitative Narrative Policy Framework

Drawing from the work of early narrative policy analysts (e.g. Fischer and Forrester, 1993; Hajer, 1993; Roe, 1994; Stone, 2012; Jones and McBeth, 2010), Gray and Jones (2016) summarize a Narrative Policy Framework (NPF) as:

> A theoretically deductive approach to the study of narrative in public policy… [which] begins by providing a generalizable definition of *policy narratives*, defining policy narratives as consisting of a setting, characters (hero, villain, and victim), a plot, and a moral of the story (i.e., policy solution[18]). The setting consists of policy-consequential facts (e.g., legally binding codes). Characters are the relevant actors in a policy narrative, consisting of those that are harmed (victims), those that perpetuate the harm (villains), and those that will correct the situation (heroes). Connecting the setting to the characters and the characters to one another is a plot that spells out the causal arrangements of the policy problem. (p. 196)

The NPF provides a "theoretical means to disaggregate the component parts of competing policy narratives, examine how they vary, and identify patterns" (Gray and Jones, 2016, p. 194). While the NPF has predominantly been used in conjunction with quantitative methods (e.g. "surveys, statistical content analysis and experiments"), Gray and Jones (2016) proposed a guide for NPF practice for use within a qualitative framework, particularly by expanding use of "induction, grounded theory, and thick description" (2016, p. 194). The resulting Qualitative Narrative Policy Framework (Q-NPF) retains the NPF's "central assumptions, theory, and structure" while "allowing for the

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[18] Gray and Jones (2016) note on page 5 that the moral of the story is *typically* a policy solution. The moral of a story may also propose a 'solution' outside the scope of public policy – as will be observed in certain 'morals of the story' in the Canadian media articles under analysis in this research.

examination of policy phenomena that is less amenable to quantitative approaches" and "expanding [the framework's] ability to speak to normative policy concerns," ultimately to offer itself to the arena of policy scholarship as an approach uniting otherwise "rival methodological approaches (i.e. positive and post-positive)" (Gray and Jones, 2016, p. 2).

Gray and Jones (2016, p. 5) note that a qualitative approach can uniquely contribute to analysing policy issues "where there are only a few stakeholders whose opinions matter (e.g., a judicial ruling)." That is partially relevant to this research, as it analyzes media narrative content debating a matter of social policy that at one stage would be decided by unelected judges in a court of law. However, during the time period of media articles under analysis, the sphere of debate also moved to the scope of decisions made by politicians, who may be more susceptible to the influence of public opinion.

Drawing therefore on the qualitative framework proposed by Gray and Jones, I conducted a content analysis of 300 Canadian media articles randomly drawn from a larger sample of 2,999 media articles on the topic of assisted suicide or euthanasia, published between 2007-2017. I gathered my full dataset of media articles and converted these narratives to PDF format for qualitative analysis utilizing qualitative data analysis software (ATLAS.ti). I applied deductive codes to the narratives based on the standard NPF coding manual from Gray and Jones, grouping competing policy positions into competing 'camps', each with their camp-specific framing of the 'MAID' plot: setting, victims, villains, heroes, and morals of the story. As this deductive coding proceeded, I also performed inductive coding based on unexpected content and patterns which emerged from the data, as per the epistemologically objectivist grounded theory process of Strauss, as articulated by Walker and Myrick (2006). Strauss's grounded theory divides the process of coding into three phases (contrasted with Glaser's two): open, axial, and selective (Walker and Myrick, 2006, p. 550). I first immersed myself in and coded the data in as many ways as possible, line-by-line, making notes as concepts and theoretical ideas emerged. Then during axial coding, I identified relationships between codes and categories. Finally, during selective coding, I integrated my categories and refined my final theory (see Walter and Myrick, 2006, pp. 551-556). Since my full initial dataset was quite large (2,999 media articles), after preliminary review and coding attempts I reduced my dataset to a random sample of 300 media articles, and performed the more comprehensive coding on this smaller but still substantial data set.

By incorporating elements of grounded theory into the analysis, Q-NPF enabled the identification and coding of emergent patterns and categories of meaning. I also incorporated the quantitative technique of tracking the frequency of codes in those categories for which there was comprehensive coding throughout the sample dataset of 300 articles, to distinguish between more popular (frequent) narrative elements and less popular (less frequent) narrative elements, to avoid exaggerating more sensational or fringe narrative elements by giving them disproportionate focus.

Data Collection

I outline below the step-by-step process I followed to collect the dataset that informed my research findings. To assess this research for trustworthiness, see the subsection *Establishing Trustworthiness in the Data* on page 44.

Initial Scoping Review

Prior to collecting media articles through LexisNexis/ProQuest for my research, I gathered 15 web-based articles to test the representativeness of the scope and nature of the media debate available through the LexisNexis/ProQuest databases. I used purposive sampling for these web-based sources since my purpose was to "select information rich cases that best provide insight into the research question" (Emmel, 2014, p. 34). First, I narrowed my scope to CBC.ca articles, as Canada's publicly funded broadcaster and most visited English-language broadcaster website (CBC/Radio-Canada Annual Report, 2002, p. 6).

Second, I searched for the term "physician assisted suicide" through the intra-site search bar. From the resulting list, I purposively sampled articles across a range of dates (both before and after decriminalization) and a range of narrative perspectives (five advocating in favour of active euthanasia, five advocating against active euthanasia, and five avoiding advocacy for either baseline position) on the basis of varying article titles and narrative content, until I felt I had a sufficiently information rich dataset against which to check the scope of content I would later find through LexisNexis/Proquest. I took detailed notes on the narrative content and structure of these initial 15 web-based sources, to familiarize myself with narrative content I should expect to see represented in the media debates. The information gained during this early step turned out to be beneficial to my later process regarding the need to change search terms due to missing pediatric articles.

LexisNexis and ProQuest. In gathering my dataset of media sources for later analysis, I began with LexisNexis, as the "most widely used news archive in the social sciences" (Weaver and Bimber, 2008, p. 516). First, I signed in to the University of Victoria library webpage, then entered 'LexisNexis' in the search bar and narrowed the results to "Newspaper". Then, I typed "LexisNexis New York Times" into the search bar and selected the link for the seventh item on that page ("Lexisnexis"). From that page, I clicked the "Full Text Online" link *below* the blue "Full Text Online" button. This brought me to the website ProQuest.

Based on the terminology most commonly used in the academic literature according to my preliminary review, and the terminology by which I found a broad range of articles on CBC.ca, I entered the search term: "Physician Assisted Suicide" into ProQuest, which generated 6,057 results. I narrowed this to a Canadian context by selecting 'Modify Search', choosing the 'News & Newspapers' database, and selecting "Canadian Newsstream". I then chose the 'Advanced Search' options and narrowed my search to include the terms "Physician Assisted Suicide" AND "Canada", and narrowed my date range to January 1st 2005 – November 30th 2017, in Newspapers, in the English language; this narrowed the results to 1,248. I chose to set the early end of the date range at 2005 to identify any shifts in the narrative framework of this issue prior to the realistic prospect of legal change in Canada in the period from 2012-2017. Though ProQuest displayed results as far back as 1991, I did not include the results between 1991 and 2004 since there was no face evidence that the 1990's results (equally low in volume) differed significantly from those of 2005 onward.

Unexpectedly, I noted that these 1,248 results omitted media articles relevant to certain post-legalization developments I was already familiar with from the initial 15 CBC.ca sources. Missing content included October 2017 articles proposing the expansion of lethal injection to infants and teenagers, as per increasing requests by parents to pediatricians. I reviewed the relevant CBC.ca article again, and identified the term used therein to be 'assisted death'. In order to include the full scope of the narrative policy debate in my results, I therefore experimented with modifying my search terms to accommodate potential public usage of this potentially more inclusive term.

Refining Search Terms to Capture Full Scope of Debate. Under 'Modify Search', I adjusted my search terms to: "Assisted Death" AND "Canada", with the same date range and other details as above. Search results included the more recent pediatrician-related articles and expanded my results dramatically, to 2,912, confirming the hypothesis that the term 'assisted death' is more common in the public discourse. I speculated that this may be since it seems more value-neutral, given the historically criminal connotations of the term 'suicide', and also more broadly applicable, given that any articles proposing to extend assisted death to infants would be unable to coherently use the term 'suicide'. Therefore, I used 'Assisted Death' to cast a wide net in seeking public narrative accounts of this phenomenon. Finally, I expanded my date range from January 1, 2005 – March 28, 2018, the date when I finalized my data collection, which produced a final result of 2,999 media articles for analysis.

Uploading Data to ATLAS.ti. I downloaded each media article individually as separate PDF files from ProQuest to a secure hard drive. I then uploaded these files en masse to the qualitative analysis software ATLAS.ti, as 2,999 separate documents within a single new ATLAS.ti project. While acknowledging concerns raised by Paulus and Lester (2016) and Silver and Rivers (2016) about the limitations of CAQDAS/ATLAS.ti software – that use of such tools may artificially steer work in an inorganic direction –these researchers ultimately conclude that there is a place for qualitative analysis software, and I agree. Specifically, the above researchers emphasized that for researchers who are properly trained and technologically proficient, ATLAS.ti provides the potential to work with larger datasets than is otherwise feasible, and to engage a "deeper levels of analysis than is possible by hand" (Paulus and Lester, 2016, p. 405). Given the large dataset with which this research is concerned, and the need to experiment with and track analytical connections of several different types between qualitative data fragments throughout this large dataset, I concluded that the CAQDAS tool of ATLAS.ti was an appropriate tool for this application.

Random Sample Generation. After preliminary coding, I realized I had a scope issue. It became clear that qualitatively coding three thousand media articles line by line, particularly such emotionally challenging content, was overambitious and unrealistic. Therefore, I decided to draw a random sample of 10% of these media articles (300 articles) for qualitative analysis.

ATLAS.ti had already automatically numbered each document upon upload (1, 2, 3, etc., all the way up to 2,999), providing each media article in my ATLAS.ti file with an associated unique integer. From here I went to RANDOM.org, selected the 'Random Integer Set Generator' tool, and generated a sequentially-ordered random set of 300 unique integers with values between 1 and 2,999. With these set results, I manually grouped the corresponding media articles in my ATLAS.ti file, and created a new ATLAS.ti file containing that group of 300 documents.

Incidental Reduction of 12-Year to 10-Year Study. Because I collected the original dataset at the end of March 2018, the 2,999 dataset cut-off point was March 28th, 2018. Because the later random sample of 300 articles inadvertently excluded documents from low-volume years 2005 and 2006 and drew 2018 articles from January only, the final dataset for analysis includes 300 media articles effectively spanning one decade, from 2007-2017, with one additional month of January 2018 to retain available data in the random sample. The exclusion of 2005-2006 data is not expected to have a significant effect on this study's outcomes since so few articles were published in that time period (five total), and they contained no features that were not captured in later documents.

Genre breakdown of random sample. Of the 300 media articles collected into the random sample for analysis, the sub-genre breakdown of article type was as follows:

- 190 documents: News Story
- 62 documents: Signed Opinion Column
- 16 documents: Unsigned Editorial (expressing opinion of 'the media outlet'/editors/publishers)
- 16 documents: Letter to the Editor
- 13 documents: Feature Story (written to inform *and* entertain, atmospheric; story behind story)
- 3 documents: Press Release (provided by organization to communicate message)

Data Analysis

Analyzing Data in ATLAS.ti

With all documents uploaded, I began to apply codes to the media articles. In ATLAS.ti, coding refers to highlighting a selection from a document (whether an excerpt of text or an image), and associating a customized 'code' title with that highlighted selection. A single code can be applied to multiple selections and multiple documents, and multiple codes can be applied to a single selection in a document. Codes can be collected together into groups with customized group names, and ATLAS.ti tools like the Code Manager and Document Manager allow the researcher to view the characteristics of codes, such as the number of quotations to which a code or code group is attached, or the number of documents in which a specified code or code group appears.

Assigning Codes to Quotations (Open Coding). During open coding, I first selected a structural category from the Q-NPF deductive coding manual developed by Gray and Jones (2016), then determined criteria by which I would code a media quotation as belonging to this larger category. My pre-set criteria for deductively applying codes in this study were:

- **Setting**: Consists of an effective "is" statement; descriptive and context-setting (e.g. description of political setting, opinion polls, foreign precedent, 'felt' atmosphere);
- **Moral of the Story**: Consists of an effective "ought" statement, i.e. proposing that an action 'should' be undertaken, whether policy-level or non-policy sphere;
- **Victim**: A character or concept framed as sustaining – or at risk of – some type of harm;
- **Villain**: A character or concept framed as perpetrating some type of harm, or otherwise embodying villainous attributes (e.g. marked by language such as "creepy" or "demanding");
- **Hero**: A character or concept rectifying a harm, promoting a good, or otherwise embodying heroic attributes (e.g. marked by lionizing language such as "courageous" or "inspiring");
- **Narrative Strategy**: Less prescriptively defined; used for emergent techniques that seemed strategically constructed to persuade, such as contested definitions of terms, narrative tone shifts from reassurance to urgency, etc.; see Findings;
- **Other**: Used for other emergent factors that were potentially relevant to an overall policy narrative. This resulted in codes such as trend association, such as 'Vets kill pets', the abortion-euthanasia connection, discussion of the Hippocratic oath, etc.; see Findings.

Initially, I attempted to code each document for all possible codes, one document at a time. I started with the full dataset of 2,999 before I decided to draw a random sample. However, I changed my procedure when I noticed myself gradually coding later documents for more and newer codes than earlier documents after seeing certain patterns recur. When I recognized a new pattern or technique, I decided to code for it, essentially the process of grounded theory. However, to provide comprehensive frequency counts across time whenever possible, this meant subsequent back-andforth to earlier documents to read and code again with newer codes. This challenge, and my adaptive response, revealed a tension I ran into with the practice of grounded theory on such a large dataset.

My response was to tackle one code category (throughout the sample) at a time, and this helped me move through each category more quickly. I was better positioned to dart back and update an old document with a code for a new pattern I'd just noticed, and comprehensiveness was improved by multiple read-throughs. I found as I coded for Category B that if I noticed I had inadvertently missed an item from Category A, I could identify it now while also coding for Category B. And so on.

During this open coding stage, I chose to apply detailed code titles to quotations that reflected potentially unique features of each excerpt, including key words from the actual quotation, attempting to avoid reducing differences between codes until the next stage: Axial Coding.

Grouping Codes into Categories (Axial Coding). Once I finished coding all 300 documents in my random sample for a top-level deductive code category (e.g. 'Moral of the Story'; 'Villain'), I exported that list of code titles to an Excel file on my secure hard drive (for example, 'Moral of the Story' included 340 distinct code titles). With each code title occupying one cell on the Excel sheet, I moved code titles around to group codes into categories. Categories were developed from codes that related to one another in a way that distinguished them from other codes. Codes were sometimes included in more than one category, which I tracked by using a different colour for codes that were being grouped into more than one category. Several code titles were in retrospect too vague or unclear for me to recall the content of their associated quotation, so I grouped those codes together to double check quotation content and renamed their code titles in ATLAS.ti later, to then be added back to my spreadsheet and grouped with the other codes where they seemed fitting as per the original process. I spent several days in this grouping stage, then returned to ATLAS.ti to group the code titles into corresponding 'code groups', using ATLAS.ti's code manager to double check the associated quotations to ensure that the code titles had appropriately reflected the content the titles had suggested to me during my intuitive grouping process, correcting any errors or duplicating any codes into multiple groups as seemed appropriate.

Refining my Categories (Selective Coding). Finally, I refined the number of categories chosen for presentation in this thesis, excluding categories that substantially overlapped with other categories. Additionally, during axial coding I thematically grouped code *titles* together. However, I wasn't able to observe the corresponding frequency count of quotations associated with each code title until viewing the material again in ATLAS.ti. Once I could observe frequency counts associated with each code (and/or overall code groups), I assessed the relative publishing-popularity of narrative elements associated with each code category and refined my theory and analysis accordingly.

Ethics

Formal ethics approval was not deemed necessary by the UVic Human Research Ethics Board for this research project, due to the publicly available nature of the media articles under study.

Establishing Trustworthiness in the Data

One might wonder how to assess qualitative research for trustworthiness. The word 'qualitative' itself suggests subjectivity, interpretation, the-unquantifiable. Following the lead of Gray and Jones (2016), I address the issue of trustworthiness in data by engaging with the four standards for trustworthiness in qualitative research proposed by Lincoln and Guba (1985). These are:

1. **Credibility**: The research should stand up to "member checks." Members of the groups from which data was collected must recognize the researcher's work as *fairly* representing their reality, even if they don't agree fully. The researcher takes care not to construct "averages" when group members hold positions adversarial to one another, and takes care not to be misled by members whose agenda may be to mislead or cover up data (1985, pp. 314-315). Credibility is enhanced by "prolonged engagement, persistent observation, and triangulation" between sources, methods, investigators, and theories (1985, pp. 301-307);

2. **Transferability**: Achieved by providing "thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility (1985, p. 316);
3. **Dependability**: Achieved by demonstrating a research design or process that can be replicated step-by-step or is otherwise ordered towards representing what it claims to represent, instead of a process ordered towards distorting what it claims to represent (1985, pp. 316-18);
4. **Confirmability**: Results (findings, interpretations, and recommendations) are demonstrated to be supported by data and "internally coherent" (1985, p. 318).

To keep this research trustworthy, I strove to meet the above criteria in this Q-NPF. Specifically, to keep this study credible, I adopted the language which each narrator chose to use when representing their own group's narrative. For instance, I included actual quotes from media narratives in which group members' words were allowed to speak for themselves, and later used this group-chosen language when summarizing the story 'plot' outlined by each group. In the three years between dataset collection and thesis submission, I reviewed every word of every media article in the original dataset of 2,999 (having already applied 909 codes to 4007 quotations before reducing to a sample size of 300 articles, in which I ultimately applied 2,060 codes to 10,270 quotations). My prolonged engagement and familiarity with the dataset goes beyond that which can be concisely captured in this thesis.

To keep this study transferable, I aimed to err on the side of describing more rather than less, to enable an interested researcher to assess whether a transfer seems possible to another area of focus. In particular, I used rich text quotations from the narrative data itself, highlighting more rather than fewer narrative characteristics, connections, trends, and recurring patterns for consideration.

To keep this study dependable, I transparently outlined my research process in specific detail. By sharing the search terms by which I created my ProQuest dataset, the process by which I arrived at my representative random sample of that dataset, and the criteria by which I assigned Atlas.ti codes to qualitative data in the sample and grouped codes into categories, a curious researcher could replicate my process to test a new random sample against the results of my own random sample.

Finally, to keep this study confirmable, I revealed my process and included direct quotes from identifiable media articles, as well as integrating the resulting data with the findings of my academic literature review, to allow the reader to determine whether the results of my research are supported by the data and internally coherent.

Limitations

Despite best efforts at utilizing methods to minimize the impact of my own subjectivity on the research outcome, I recognize that one of the primary limitations of this research is the person behind the pencil (me). For example, to minimize the impact of my own bias, I tracked the 'frequency' of narrative content recurrence to differentiate between popular narrative elements and fringe narrative elements, to ensure that fringe narrative elements would not disproportionately attract my attention. I wanted to avoid any correspondingly disproportionate representation of the overall dataset. However, the qualitative coding of quotations – and grouping of codes into categories that could be referenced as 'one' narrative element recurring at high frequency – was necessarily a matter of human judgment. Whereas Atlas.ti is capable of running automatic processes to capture specific pre-defined terms (e.g. "dignity", "autonomy", "euthanasia"), this was not my primary method of assigning codes to quotations. I judged that this sort of rigid term-searching risked missing the nuances of human language. For example, there are many ways of narratively framing a character as a hero – and most of these don't involve the word 'hero', nor can the search terms be anticipated in advance. One article might lionize an individual as "courageous"; another might mention how much they "admire" someone; another might describe applause in the street, or a situation in which one person is contextually framed as rescuing another. These diverse ways of expressing heroizing characterization require a human eye and mind to identify.

At the same time, in applying human judgment to interpreting underlying meanings of communication, and later grouping together multiple codes into categories that shared common features, my human intuition was involved, and another person might have coded or grouped the same data differently. Therefore, I consider this research both accurate and representative of the data, while not necessarily the only lens through which the data might be analyzed. I invite my reader to consider the 'fit' between the media excerpts I share and the code categories to which I assigned them, to consider whether the organizing concepts I have applied seems like a reasonable fit to the data.

Another potential limitation was assigning narrative 'camp' (*Freedom*, *Protection*, *Fence-sitting*) to certain quotations. This was especially a challenge when parsing *Protection* from *Fence-sitting* narratives; these were often near identical – e.g. in peripheral narrative elements about palliative care or conscientious objection rights – except that a *Protection* narrative included explicit advocacy against baseline legal MAID. Camp assignment was also a challenge in rare cases that struck me as true judgment calls. For example, the case of an author who otherwise only writes ardent *Freedom Camp* advocacy pieces… expressing in one article arguably only a *Fence-sitting* narrative element… which is otherwise exclusively used by *Protection Camp* advocates. In this and other complicated cases, I assigned 'camp' designations based on my best estimation of how the message would likely be received by an average media audience that was unfamiliar with an author's other work. At times this involved, for lack of a better phrase, my instinctive sense, and I applied my judgment – and performed coding – accordingly. If my best judgment in these few tricky narratives led me to any conclusions that someone else might consider 'in error,' I hope that in the bigger picture, such potential 'errors' canceled out.

Finally, this research was limited by restrictions on time and financial resources. For this thesis, it became necessary to narrow my focus and cease to explore the many branches of available inquiry to which this research moved me. Further, certain narratives simply were not represented in the random sample — for example, a First Nations politician discussing perceived incompatibilities between MAID-consistent cultural values and certain First Nations cultural values, and concerns about the risks of MAID legalization on First Nations persons — because they were too rare in the larger dataset to be scooped up by a 10% random sample. Therefore I note that although some narrative elements may get little (or no) attention in this research, there is much more to be explored and discussed, and the conclusions of this research do not exhaust the potential of the dataset.

Findings Section

Roadmap of Findings

Freedom Camp *Policy Narratives*
(promote laws enabling suicide assistance / active + direct euthanasia)

Vs.
Protection Camp *Policy Narratives*
(promote laws prohibiting suicide assistance / active + direct euthanasia)

Vs.
Fence-sitting Camp *Policy Narratives*
(avoid promoting either baseline legal status; focus on peripheral issues)

Due to the considerable use of rich-text quotations and sub-categorization provided for the reader's reference, the Findings section of this thesis is divided into four chapters:

I begin each of Chapters 4, 5, and 6 by summarizing the criteria by which a narrative element was qualitatively coded as belonging to the associated policy narrative camp. I then summarize and provide excerpted quotations (usually one per subcategory, for brevity) from the media narrative content under analysis, according to the following categories of narrative element, of which each policy story was composed: Setting; Cast of Characters (Victim, Villain, Hero); Moral of the Story; and Narrative Strategy. Finally, in Chapter 7, I weave together the narrative elements into continuous, summarized 'Plots' for each policy narrative camp, to present one overarching, approximately representative narrative per policy camp.

Tables of contents for quick reference to subsections within chapters are found within Chapters 4, 5, and 6, on the pages introducing each chapter's cast of characters, and the pages introducing each chapter's moral of the story.

Chapter 4: ***Freedom*** Camp Policy Narratives

The *Freedom* policy narrative camp supports baseline decriminalization of suicide assistance and/or active + direct euthanasia (see Figure 1 in Chapter 1). For a narrative element to be categorized within the *Freedom* policy narrative camp, a narrative had to express support for baseline decriminalization of suicide assistance and/or active + direct euthanasia. Originally labelled the 'Pro Assisted Death' (PAD) camp in recognition of *Freedom* narratives' linguistic framing of the procedure in question as "assisted death", I subsequently renamed the camp to avoid using either an unwieldly three-word label time after time, or an acronym the memorization of which a reader might find distracting. I chose to rename this policy narrative camp '*Freedom*' because of the typical emphasis of these narratives on 'freedom' as an absolute bottom-line value undergirding their argument (amid related concepts frequently co-valued by these narrators such as 'autonomy' and 'independence'). That is, the argument in favour of legalizing (and expanding) suicide assistance and/or active + direct euthanasia in Canada was typically expressed by its supporters as rooted in beliefs that this is necessary not because of lack of good palliative care or supported living alternatives, but because an individual should have the freedom to choose the manner of their death, full stop. Such an underlying drive for 'freedom' was expressed, for example, in media excerpts such as (emphases mine):

> "It's not a question of good care," de Vries counters. "What counts is freedom." She says the people she speaks to don't want to be placed "behind bars" in nursing homes… Bus also yearns for the independence she lost 23 years ago. (Toronto Star, Feature, Feb 2015)

This chapter analyses the *Freedom Camp* narrative policy position. It examines the *Freedom*-framed setting, characters, moral of the story (i.e., preferred policy), and most prominent narrative strategies employed by the *Freedom Camp*. Category-representing media examples with underlined emphases are included. As shorthand, I refer to *Freedom Camp* policy advocates as *Freedom* advocates.

Setting (According to *Freedom Camp* Policy Narratives)

Freedom Camp policy narratives collectively describe the setting of this story as:

1. Socially divided between the compassionate and the cruel;
2. Atmospherically imbued with intense fear of suffering and meaninglessness;
3. One in which lives of chronic illness, not health, are being artificially prolonged;
4. One in which suicide is the inevitable alternative to severe suffering, and the only choice is whether to help people access less messy methods at more preferred times;
5. One in which foreign jurisdictions have set a positive precedent to follow;
6. One in which Canada already allows morally equivalent but experientially inferior practices;
7. One in which the *Freedom-fighting* cause is led by Cascadian ecospiritualists, Quebecois secularists, liberal religious, religious 'nones', and baby boomers; and
8. One in which the Canadian public overwhelmingly supports the *Freedom Camp* position.

Details and media examples follow.

1. Social Division between the Compassionate and the Cruel

According to *Freedom Camp* policy narratives, the social setting is divided between people who are compassionate (*Freedom* advocates), and people who are mysteriously cruel or indifferent. Subcategories of characters deemed cruel or indifferent will be found in the 'Villain' cast, from p. 59.

> "… it is a significant step in the right direction ... a step towards kindness and <u>compassion</u> and a step away from fear and <u>closed-mindedness</u>," she said. (The Globe and Mail, Feature, Feb 2015)

> <u>I will never understand</u> how some hospitals and doctors can be so <u>cruel</u> to those who cry out for mercy. (Prince Albert Daily Herald, Opinion, Nov 2016)

2. Intense Fear of Suffering and Meaninglessness

For *Freedom* advocates, suffering is inherently pointless and potentially unendurable. Life, as one *Freedom* advocate puts it, isn't a competition to see who can bear the most. *Freedom Camp* narratives typically frame dignity and meaning as 'loseable'. To endure bodily deterioration or suffering is framed as barbaric by *Freedom* advocates when the 'civilized and clean' solution of lethal injection (or a 'lethal cocktail' for oral consumption) is available. High-intensity word choices ("agony," "soul-crushing"), and settings atmospherically imbued by intense fear of such suffering, are common.

> Meg Westley, president of Dying With Dignity, understood the agony… Fifteen years earlier, she watched her mother's "wretched" death to breast cancer. She lost her breast, vision in one eye, her hair, she developed hideous widow's hump on her back and became bedridden and in pain. It was a barbaric situation. You witness it and think, 'What's the point of this?' It was miserable, undignified, horrible, and she wished there was an easy exit." For her, there wasn't. For Nagui, there could be, she believed. (The Spectator, Feature, Sept 2012)

3. Technology is Artificially Prolonging Chronic Illness, not Healthy Life

Freedom advocates sometimes argue that MAID is necessary *because* of technological developments that have prolonged low quality lives characterized by the distressing ups and downs of chronic illness. When life-prolonging measures were critiqued in *Freedom Camp* policy narratives, *Freedom* advocates often expressed that opponents of MAID must support artificial life-prolonging measures or have an unhealthy fear of death itself, rather than just opposing MAID:

> Campbell pressed her finger over her breathing tube each time she spoke, allowing air to pass through her voice box. Facing death made her reflective, she said. "We all know we're going to die, but we don't have it in our heads. I think, culturally, we have a lot of escapism. When you look at the time before antibiotics, in the 1900s, you were grateful to be alive. But in the 2000s, we're looking for a way to get out of this life. . . . When you have people who are chronically ill, they're desperately ill, then recover, then desperately ill, then recover. When you have medical assistance in dying, your focus can be on a comfortable death." (The Vancouver Sun, Feature, Jan 2017)

4. Suicide is Inevitable: Prohibiting Suicide Assistance Only Makes Suicide Messier

Freedom Camp narratives describe the setting as one in which suicide is inevitable, with the prohibition against suicide assistance directly leading to messier 'too-soon' suicides:

> This creates a Catch-22 for patients suffering from degenerative illnesses. Either you kill yourself in some clumsy, awful, amateurish way - with a gun, a knife, a bottle of pills, or a bridge - while you still are well enough to feed the cats. Or you wait till you're so debilitated that life becomes unremittingly awful ... but by that time, you can't perform the final deed yourself. (National Post Column, Feb 2015)

5. Foreign Jurisdictions Set a Positive Precedent to Follow

Freedom advocates present foreign jurisdictions as role models, and data sources that – *Freedom* advocates argue – demonstrate safe and positive outcomes. International precedent narrative elements of the setting typically take two forms: abstract claims about foreign evidence, and anecdotal descriptions of suicide-assistance events (typically in Swiss Dignitas clinics). Such events are presented in atmospherically warm terms, describing high-affection and occasionally spiritualized/ritualized activities that culminate in a positive-feeling death experience:

> The hosts, Erika and Horst, "came out and hugged all of us," said Lee. Erika, an elderly nurse, knelt down in front of Kay in her wheelchair and asked, "Are you ready?" Kay answered, "I sure am." After filling out more paperwork in the room where Kay was going to die, the family hugged and talked and reminisced. They took a photo of themselves on the deathbed, with Kay smiling, squeezed in the middle of her beloved family. "No one was in a hurry for anything," Lee recalled. She said Erika "lovingly" asked Kay what she would like to do, whether she would like to talk more. "Mom said, 'No. Let's go. I'm ready.'" After Kay swallowed the barbiturate, Erika put her hands on her knee and said: "Have a good journey, Kay. I'll see you on the other side." Kay fell asleep, and began to snore. When Horst said Kay could probably hear what they were saying, they began reminiscing about things their mother and father had done together. Twenty minutes later, Horst said Kay had "left us." Erika then opened the door of the room, saying she was "letting Kay's spirit leave." The family sat for five minutes or more. Horst asked if anyone would like cognac. "I'd love one," Lee answered. "We weren't sad. Just tired. We all just thought, 'Oh my God, that was the most powerful experience we could ever imagine.'" (Star – Phoenix, Feature, Feb 2010)

6. Canada Already Allows Morally Equivalent but Experientially Inferior Procedures

Freedom advocates describe pre-2015 Canadians laws (which permitted passive and indirect euthanasia; see Figure 1 in Chapter 1) as enabling procedures *Freedom* advocates consider morally equivalent to active + direct euthanasia, but experientially inferior. Alternate widely-applicable terms (e.g. "accelerated death") are used by *Freedom* advocates to articulate this perception:

> Of course, the euthanasia elephant in every palliative-care centre is how accelerated death is a routine procedure, albeit labelled as withheld treatment or a painkilling medication overdose. (National Post, Opinion, Oct 2009)

7. This Conversation is Led by Baby Boomers, Liberal Religious, and Secularists

Freedom narratives describe the current debate as being led by people who have observed loved ones die in disturbing conditions, and now fear their own future death. Prominent voices identified also included: baby boomers accustomed to controlling and optimizing experiences, Cascadian eco-spiritualists and Quebecois secularists, and location non-specific liberal religious, or religious 'nones'.

> Most of my friends have seen their parents through searingly difficult deaths. They are now wondering about their own. Like them, I fear the following: an existence as I age with little agency or quality of life, burdening my family, and a protracted and pain filled death. So I will sign any directive I can to make sure I am in the driver's seat when it comes to my own death. And of course, we baby boomers, with our fixation on optimized life experiences, would naturally turn dying well into a consumer product. (Toronto Star, Column, Feb 2017)
>
> A freethinking ecological spirituality informed Bennett's self-chosen death. That has been the case for many British Columbians who have campaigned for decades for the ruling supporting "death with dignity" that the Supreme Court of Canada delivered on Feb. 6. This pro-euthanasia environmentalist spirituality of B.C., as well as of Oregon and Washington, is captured in the book Religion and Public Life in the Pacific Northwest: The None Zone... Pacific Northwest residents' passion for legalizing assisted suicide is rooted in libertarian, spiritual-but-not-religious and liberal Christian world views, Killen says. Supporters of assisted suicide have maintained they are bringing together "individual freedom, loving social relationships and natural beauty into a moment of profound human dignity." Residents of the Pacific Northwest, also known as Cascadia, have made an outsized contribution to the cause of assisted suicide... Why…? … This is the least religious region of the continent - and one of the most anti-institutional. The residents of Cascadia are more likely than other North Americans to tell pollsters they have no religion (which leads to them being dubbed "religious nones")… Quebec's citizens have promoted secularization and, similar to those in Cascadia, had some of the lowest rates of religious attendance. Pollster Reg Bibby says Quebecers, along with British Columbians, are the most liberal in Canada… As Ipsos Reid's Darrel Bricker and writer John Ibbitson suggest in their book, The Big Shift, the campaign for assisted suicide has emerged out of B.C. and Quebec… (Sunday Phoenix, News, Feb 2015)

8. The Canadian Public Overwhelmingly Supports the *Freedom Camp* Position

The *Freedom Camp* presents everyday Canadians as 'savvy' (see *Freedom* Heroes) and argues that the movement to legalize MAID has enjoyed popular support among the general public (typically alluding to opinion polls). MAID legalization is presented by *Freedom* advocates as inherent to progress:

> We are living in the 21st century and people should have a right to "die with dignity" and not have to travel to abroad to do so. No one is saying anyone who disagrees with this Supreme Court decision "must act on it," but leave the other 90 per cent of Canadians who do agree with this decision to look forward to not having to leave the country to "die with dignity." You, sir, are in the minority. (Daily Gleaner, Letter, Feb 2015)

Cast of Characters (According to *Freedom Camp* Policy Narratives)

180 documents (60% of documents) contained *Freedom* characterization: that is, at least one appearance per document of at least one *Freedom*-framed victim, villain, or hero. *Freedom*-framed victims appeared in 130 documents (43.33% of all documents); *Freedom*-framed villains appeared in 110 documents (36% of all documents); and *Freedom*-framed heroes appeared in 85 documents (28.33% of all documents). Of the *Freedom* character cast, 40% were victims; 34% were villains; and 26% were heroes.

Victims	Pg.	Villains	Pg.	Heroes	Pg.
72% Suffering Patient…..	60	19% Politicians……………..	64	25% Country, Gov't…..	69
13% Family or Friends…..	62	19% Unjust Laws…………..	64	18% Health Workers…..	69
7% Health Workers…….	62	17% Religion……………….	65	15% Patients…………...	70
4% General Public……..	63	11% Health Workers……….	65	12% Court, Judge……...	70
2% Healthcare System…	63	7% Ignorance……………...	65	10% General Public……	71
2% Activist org..............	64	6% Healthcare System…….	66	6% Family or Friends...	71
		5% Activists……………….	66	6% Activists…………..	72
		5% Misc. Specific…………	66	3% Healthcare System..	72
		3% "Those who…"……….	67	3% Law/Policy……….	72
		2% Background Situation…	67	2% MAID itself………	73
		2% Discourse……………...	67	1% Misc. Specific……	73
		2% Law Enforcement……..	68		
		1% Family or Friends……...	68		
		1% Prospective Recipient…	68		

Victims (According to *Freedom Camp* Policy Narratives)

40% of the *Freedom* story cast (appearing in 130 media articles) were victim characters. In descending order of frequency, victims as cast by the *Freedom* narrative included:

The Suffering Patient

The primary victim of the story as told by the *Freedom Camp* was the 'suffering patient', representing 72% of *Freedom*-framed victim characters across 123 media articles.

Prior to Canadian legalization of MAID under the original limited criteria, the suffering patient victim in *Freedom* narratives was framed differently depending upon whether the victim was hypothetical or anecdotal. In both cases, the suffering patient victim was typically framed as a mentally healthy, cognitively competent adult, whose natural death from illness was reasonably proximate. In hypotheticals, however, this victim was typically framed as being in irremediable physical pain, while anecdotes tended to focus not on physical pain, but on psychological distress associated with physical functionality, or social concerns.

> Dr. Low describes the toll cancer had taken on him physically – the debilitating effects on “my vision, my hearing, my strength.” “I’m worried about how it’s going to end,” Dr. Low said, leaning back into a couch, his right eye almost entirely closed. “I know it’s going to end, it’s never going to get better. So, I’m going to die. What worries me is how I’m going to die,” he said. “Am I going to end up being paralyzed and have to be carried from the bathroom to the bed? Am I going to have trouble swallowing? I won’t be able to take in food? What the end is going to look like, that’s what’s bothering me the most.” (National Post, News, Sept 2013)

Subsequent to Canadian legalization of MAID under the original limited criteria, already-near-death suffering patients were reframed as the *least* in need of MAID, since death would come soon to such persons anyway. The *Freedom*-framed ‘suffering patient’ victim category was expanded to emphasize suffering from any subjectively intolerable condition with no ‘rescue’ of natural death in sight. This suffering patient category was especially expanded in *Freedom Camp* narratives to include persons with mental illness, minors, and persons who may wish to sign an advance directive to receive MAID under specified future conditions. More fringe expansion proposals included bereavement grief or loneliness of persons in nursing homes, endorsing “Freedom of Choice” as the only qualifying criterion.

> The "people you seek to deprive of a dignified physician-assisted death are those who may need it the most and who are not in the least bit 'vulnerable,' " he concluded. The bill seems to be directed at end-stage cancer patients, people for whom death is a given, even if the timing cannot be predicted precisely. It shuns people with refractory depression, those who are under 18, and denies access to dementia patients who have stated their end-of-life wishes in advance directives completed after diagnosis but while they were still competent. Who will speak for the suffering for whom no end is in sight? (The Globe and Mail, Feature, Apr 2016)

> How many of us have seen the utter despair of a man or woman when a partner of 60 years suddenly dies? Or, witnessed the lonely, forlorn, look of those in nursing homes void of family and friends. They endure a life without meaning, waiting for it to end. Surely, these people have a right to MAID if they desire it. After all, it's their life, not ours… Freedom of Choice should

> determine who qualifies for MAID, not a hospital, doctor or a court of law. (Prince Albert Daily Herald, Opinion, Nov 2016)

Family or Friends of the Suffering Patient

The secondary victims of *Freedom* narratives (at 13% of *Freedom* victims) were family or friends of a suffering patient framed as burdened by the costs of caregiving; as suffering traumatic shock if they discover the body of a loved one after an unexpected and messy solo suicide; or as risking legal consequences if they assist in a loved one's openly-planned suicide.

> "After dealing with more than 500 suicides over 30 years as a Windsor area coroner, Dr. Robert Drake has concluded that assisted suicide should also be available to those who have simply decided to end their life. He's seen too many devastated family members who discovered the body of a loved one after a shocking and horrible suicide. "He can come to a much more graceful and sensitive way of dying, rather than hiding in a closet until everyone goes out and hanging himself in the hallway," Drake said." (The Windsor Star, News, March 2016)

Frontline Healthcare Practitioners

7% of *Freedom*-framed victims were frontline healthcare practitioners who watch patients suffer without being permitted to perform MAID, or who risk prosecution (pre-legalization) or social disapproval (post-legalization) if they choose to participate in MAID. An illustrative example from a 2012 lengthy feature-genre article alludes to both types of physician victimhood (emotional/psychological and social/legal) from the *Freedom* advocate perspective:

> What would Toronto neurologist Dr. Sharon Cohen do if a patient wished to escape the slow, inescapable torment of a terminal disease through suicide? Would she agree to help if the patient asked? She pauses thoughtfully for several seconds. "I'll say no," she finally declares, her eyes rising to make direct contact. Has she assisted patients to die in the past? "Again, I'll say no." It's the kind of careful phraseology used by many Canadian physicians torn between the threat of imprisonment for assisting a death in Canada and the instinct to help patients pleading for relief… "You have to worry as a physician how the public, your patients and your colleagues are going to view you," Cohen says… "We can't cure everything. I don't understand being inhumane. And yet, we are. It's a real paradox… And I've seen some people who are heartbreaking because the best thing for them is for their life to end. I would never say that to them, but sometimes I know it." In those moments, when a patient pleads for help, the confusing, messy, amorphous questions of law and morality re-emerge. Her eyes make direct eye contact again, glistening this time. "People don't think about how physicians feel about this," she says. "I would want to assist, but the law says I can't." (Toronto Star, Feature, Oct 2012)

Post-legalization *Freedom-framed* health worker victims often concerned bureaucratic difficulties experienced by doctors who participate in MAID, and fear of punishment lest a “good faith” decision to perform MAID later be second-guessed by an oversight body:

> … eight months after legalized doctor-assisted suicide took effect in Canada, doctors who have carried out the act say the issue is far less about moral or psychological angst than it is about the legal ambiguities and uneasiness involved. … Last fall, the commission overseeing Quebec's euthanasia law, the first of its kind in Canada, reported 262 completed euthanasia deaths in the first nine months of the law. Of those, 21 cases were found to be non-compliant with the regulations. In most of those cases - 18 - the two doctors who assessed the patient were considered not sufficiently independent. Of the remaining three, the commission ruled that two of the people were not at "end of life" while the third, according to the panel, didn't have a serious and incurable condition... "You have to imagine that if you're one of those physicians, you might be pretty upset that a panel of people (the oversight commission) - none of whom have ever performed medical aid in dying and only two of whom are physicians - is secondguessing your medical judgment," Downar said. (The Windsor Star, News, Feb 2017)

The General Public

The general public were framed as 4% of victims in *Freedom* narratives, insofar as they may be exposed to the traumatic sight of messy public suicides (e.g. window jumping); risk future decline without a “defined way out”; may have their wishes mediated in a costly and inefficient court system; and shouldn’t have to live or die by other people’s religious views:

> He described approving the euthanasia of a 95-year-old woman who had lost all her friends and had given up on living. "Maybe if you say to that kind of person, 'We are not going to give you euthanasia,' they open the window on the fourth floor and jump down. And that's traumatic for everyone," he said. (Leader Post, News, Oct 2015)

The Healthcare System in General

The ‘healthcare system’ embodied 2% of *Freedom Camp* victim cast (sometimes referenced as the “government” or “welfare state”), which was framed as victimized insofar as it risks being over-burdened or having its finite resources drained by what is often costly end-of-life care:

> Just as environmentalists fight for careful use of the planet's resources, Bennett wrote on her website, Death at Noon, she did not want to waste the finite resources of her (well-off) family or the government. She felt it absurd to have medical staff fussing over her body while it was an "empty husk." (Sunday Phoenix, News, Feb 2015)

The "Dying with Dignity" Political Activism Organization

This organization embodied 2% of the *Freedom Camp* victim cast when its charitable status was annulled by the Canada Revenue Agency in 2015, after a political activity audit revealed this status had initially been assigned in error:

> It is also unconscionable that the organization "Dying with Dignity" has lost its charitable status which makes its operation more difficult. (Niagara This Week, Opinion, Dec 2015)

Villains (According to *Freedom Camp* Policy Narratives)

34% of the *Freedom* story cast (appearing in 110 media articles) were villain characters. In descending order of frequency, villains as cast by the *Freedom* narrative included:

Lazy, Cowardly, or Discriminatory Politicians

19% of *Freedom*-framed narrative villains (across 33 articles) were politicians framed as lazy or cowardly, as developing a conservative bias in office, or as too slow to enact MAID-enabling policy changes. Such politicians were framed as wanting to "discriminate" against whole groups of people by restricting access to MAID, or framed as too responsive to minority-representative interest groups while being too unresponsive to the broader public's wishes:

> Shanaaz Gokool, head of Dying with Dignity Canada, said her group is "really concerned" that the government appears intent on introducing a relatively restrictive law that "discriminates against whole groups of people." "If they want to exclude groups of people based on age as opposed to capacity, if they want to exclude groups of people because they have a particular kind of illness that will lead them to incompetency, then they're faced with a few options," she said. (Chronicle-Herald, News, Apr 2016)

Unjust Laws

Unjust laws embodied 19% of the *Freedom* villain cast, framed as mechanistically breaching rights or actively condemning humans to severe and intolerable suffering:

> …the [bill's] requirement that a patient's natural death be "reasonably foreseeable"… is unconstitutional and condemns Canadians who are not terminally ill to years of suffering… (The Globe and Mail, News, June 2016)

Religion and the (Conservatively) Religiously Affiliated

17% of *Freedom* narrative villains (across 29 articles) were some manifestation of religion or the religiously affiliated who were framed as ignoring suffering or as wanting to impose extremist minority morals on others:

> Cardinal Thomas Collins' recent statement on assisted death represents an extreme perspective that ignores the suffering people who have advocated for assisted death have and continue to experience -- suffering that deserves relief… I am not Catholic, and I do not want views rooted in a religion I do not ascribe to imposed upon me or others in a similar position. Freedom of religion (for me) means Cardinal Collins' narrow views should not be imposed upon the rest of society. (Winnipeg Free Press, Letter, Mar 2016)

Frontline Healthcare Practitioners

11% of *Freedom* narrative villains (across 20 articles) were frontline healthcare practitioners who oppose MAID. These health worker villains were characterized by *Freedom* advocates as demanding and self-focused, as thinking their personal feelings or moral beliefs matter more than what patients want, and as making an inappropriate and unacceptable choice to abandon patients to suffering by failing to either perform MAID or at least refer for MAID. In *Freedom Camp* narratives, a physician abstaining from participation in MAID, including abstaining from referral for MAID, was characterized as 'forcing' undesirable experiences upon a patient:

> Others said that while doctors clearly have a right to opt out, it would be inappropriate and "unacceptable" not to refer that patient on to another doctor. "Being a physician does not mean you get to force your patient to live their life in accordance with your personal choices," one doctor wrote. (The Ottawa Citizen, News, Aug 2015)

Fools; Fearmongering Ignorance And Naivete

7% of *Freedom* narrative villains (across 13 articles) were the concepts of ignorance or naivete, or persons or organizations framed as "fools" in their role as politician, activist, lawyer, or other profession. In this category, a text had to primarily cast foolishness itself (or 'the foolish') as villainous, regardless of whether a given 'fool' might be identifiable:

> Years ago I wrote that "The problems of the world are caused by supposedly intelligent people who are largely fools." I haven't changed my mind as I look at the problems surrounding the

> new law that allows Medical Aid in Dying (MAID)… the current law states that extreme suffering is not always sufficient grounds for MAID. This means stroke victims and others could linger for years before being "reasonably" close to death. How could anyone pass such asinine legislation? (Prince Albert Daily Herald, Opinion, Nov 2016)

Healthcare Institutions

6% of *Freedom* narrative villains (across 11 articles) were healthcare institutions, most frequently a hospice or hospital with policies prohibiting MAID on-site, requiring patients to be transferred to other locations in the event of a request for MAID.

> Catholic hospitals and some non-Catholic facilities do not allow doctors or nurse practitioners to assist patients in dying… He had to be transferred to another hospital. This is difficult for anyone near the end of life, particularly if you're in severe pain. His daughter reported, "My Dad yelled out in agony as they lifted him from his bed to the stretcher. He cried out at every single bump in the ambulance." … I believe it borders on criminality to move dying patients to another hospital for MAID. (Prince Albert Daily Herald, Opinion, Nov 2016)

Disability Advocates and Anti-Euthanasia Interest Groups

5% of *Freedom*-framed narrative villains (across eight articles) were disability advocates and anti-euthanasia interest groups framed as 'arrogantly' trying to impose views about suffering as tolerable, or trying to "deny Canadians their constitutional rights."

> As to various interest groups, organized or informal, far too many of their statements have urged government to ignore or alter the intent of the court. Have they read the decision? If so, how do they justify trying to deny Canadians their constitutional rights by again bringing up concerns the court ably and explicitly dismissed as unfounded? Such presentations are irrelevant to the committee's work. The groups lost and don't accept it. (The Times-Transcript, Opinion, Feb 2016)

Miscellaneous (Specific, Professional) Opponents to MAID

5% of *Freedom Camp* narrative villains (across eight articles) fell into the category of professionals opposed to MAID. Most of these referenced Dr. Chochinov, the Canada Research Chair in palliative care, and Catherine Frazee, disability rights lawyer and former chief commissioner of the Ontario Human Rights Commission. These two were framed by *Freedom* advocates as inherently biased or biasing members of a government-appointed panel tasked with developing guidelines and safeguards for MAID. In another article, an Alberta doctor assigned to assist with implementing MAID was villainized due to his personal opposition to the practice.

> With questions swirling about access to assisted-death in the province, one advocate said Wasylenko's job as chairman of the Alberta Health Service's secretariat on "preparedness for physician-assisted death" is a concern. "I think it absolutely raises some red flags," said Brad Peter, an Edmonton- based director of Dying with Dignity. "If Alberta was to get this wrong now, this would be an absolute tragedy, and an embarrassment." (Montreal Gazette, News, Mar 2014)

"Those who…" (Oppose MAID)

3% of *Freedom* narrative villains, across six articles, are best summed up as the otherwise unspecified "those who oppose MAID". In the example below, the belief that support for MAID is natural to all those who have watched a loved one suffer at the end of life implies that those who oppose MAID must not have watched a loved one suffer:

> There will always be those who are opposed to assisted death. Those who have watched a loved one suffer for any length of time at the end of their life will welcome the Supreme Court's decision. (North Shore News, Opinion, Feb 2015)

Background Situation or State of Affairs

2% of *Freedom* narrative villains, across four articles, were background situation or state of affairs. These included a *Freedom*-perceived "slow pace" of legal change in Canada, and parliamentary democracy itself, framed as systematically tilting majority governments to a "chronic aversion to risk."

> One of the great ironies of parliamentary democracy is that majority governments tend to be inherently conservative on tricky social issues. Having achieved power, governing parties are loath to do anything to rock that boat. (Winnipeg Free Press, Opinion, Apr 2014)

Discourse (Inflammatory Language)

2% of *Freedom* narrative villains, across three articles, were villainous form or content of discourse. In *Freedom* narratives the primary discourse villain is framed as being inflammatory language: specifically, language that stigmatizes MAID or MAID policies as unjustly imposed.

> One of the 21 recommendations put forward by the parliamentary committee advising on doctor assisted death is: "The committee recommends the Government of Canada work with the provinces and territories to ensure that all publicly funded health care institutions provide

> medical assistance on [sic] dying." Twice, in news coverage of this report, the word "edict" is used to describe this recommendation. The use of this terminology is inaccurate, inflammatory and biased. (Edmonton Journal, Letter, Mar 2016)

Law Enforcement

2% of *Freedom* narrative villains were law enforcement officers who might interrupt a patient's last wishes or make problems for family members who assist in a death.

> For reasons involving Canadian law and the fear of a police investigation… neither Kay nor her daughters and son told anyone in Canada that she had been planning her death for six months. They did not want their mother's last wish to be interrupted by police… The children told their mother they'd support her. Given Canadian law, Lee said she and her siblings had to "live in a bubble" of silence from that day on. "No one could know what we were doing. Somebody might have stopped us." (Star – Phoenix, Feature, Feb 2010)

Family Or Friends Who Oppose A Loved One's MAID

1% of *Freedom* narrative villains fell into this category, which included a wife who self-identified in retrospect as having been "cruel" to try to prevent her husband's suicide:

> Mr. Bastable had already tried to take his own life by ingesting his stockpile of pills while his wife was at work. She discovered him and called emergency services. Three days later, when he woke up in hospital, she looked at him and said, "I'm so sorry." That was when she realized, as she explained on an episode of the CBC Television program Man Alive, that as much as she wanted her husband to live, it was cruel to thwart his desire to die. (The Globe and Mail, Feature, Apr 2016)

A Prospective Recipient of MAID

Lastly, one prospective MAID recipient framed herself as a *would-be* villain ("negligent") if she didn't advocate to improve access to MAID for others.

> "Some people might think I'm too capable, but why should you wait until you have to roll me in?" Campbell said. "I'm ready." … She chose to share her story in the hope that it might open the door for others facing death and draw attention to gaps she saw in the process. "I have this feeling that if you're not part of the solution, you're part of the problem. With my background, the failure to do something would be negligent," she said. (The Vancouver Sun, Feature, Jan 2017)

Heroes (According to *Freedom Camp* Policy Narratives)

26% of the *Freedom* story cast (appearing in 85 media articles) were hero characters. In descending order of frequency, heroes as cast by the *Freedom* narrative included:

Country, Government, or Government Representatives

25% of *Freedom Camp* narrative heroes, across 29 articles, were country, government, or government representatives, especially: Quebec's provincial government, hailed as perpetually "ahead" of the rest of Canada in pushing for "groundbreaking" social change; Canada overall, for being "progressive" and promoting autonomy by legalizing MAID; politicians who support MAID contrary to their own party's positions; and foreign jurisdictions like the Netherlands, for having a "liberal" approach to euthanasia.

> "Quebec, a Roman Catholic province, has always been ahead of the rest of Canada in social change. Now it appears that it won't be too long before Quebec will be the first province to allow assisted death." (Niagara This Week, Opinion, Dec 2015)

Compassionate Physicians

18% of *Freedom* hero characters, across 21 articles, were the physicians framed as compassionate enough to assist in a suicide or perform lethal injection, either covertly before decriminalization or overtly after legalization. Their expertise and ethics were praised as trustworthy to apply appropriate guidelines for implementing MAID in even tricky cases. The following media excerpts provide examples of *Freedom* physician heroization…

… prior to the decriminalization of suicide assistance in Canada:

> While Morcos felt most of his doctors at North York General were disapproving of his plans to end his own life, Dr. Sharon Cohen was different. She listened carefully as he explained his plans to her last year. Then, he asked her opinion. It's a difficult question for a doctor in Canada. Assisting suicide is illegal... "I made it clear that I fully supported him and everything he was saying and doing made sense to me," Cohen says. "He felt good that I did agree. He was very grateful." She put him through cognitive testing to make sure that he was of sound mind and that his mental capacity was well-documented. Then, she worried. "It was a stressful period for me," she says. "I felt nervous about whether I was doing the right thing from a legal standpoint and what the law might have to say about the conversations I had with him, although I felt

> morally I was absolutely doing the right thing." … Cohen's voice begins to soften and break when she recalls the impact Morcos had on her, both professionally and personally… "…I felt even more committed to be the best doctor I can for people. You couldn't help but be inspired. He did the right thing for him." (The Spectator, Feature, Sep 2012)

… after the decriminalization of suicide assistance but before legalization of regulated MAID:

> "Cases involving mental illness may prove challenging to address for health care practitioners, but the Committee has faith in the expertise of Canadian health care professionals to develop and apply appropriate guidelines for such cases," the report says. (The Globe and Mail, News, Feb 2016)

… and after the new law was enacted to regulate formalized MAID:

> "My last one, he'd had three cancers, heart and lung disease. His wife climbed into bed with him," Wiebe says with a smile. "He was 72. He was counting down the hours. He called me his angel." (The Vancouver Sun, Feature, Oct 2016)

Patients Who Choose or Advocate for MAID

15% of *Freedom* heroes, across 18 articles, were prospective MAID recipients themselves. These characters were typically lionized as defiant, independent free thinkers who courageously choose a noble death on their own terms, whose approach to death inspires others, or who advocate to enable others to make the same choice.

> After being diagnosed with amyotrophic lateral sclerosis, or Lou Gehrig's disease, in 1991, the Victoria woman made national headlines and captured the public's attention by asking a simple question. "If I cannot give consent to my own death, whose body is this? Who owns my life?"… It was early March in 1993… She was 42 years old and had been living with ALS for two years. When the press conference ended, Rodriguez, accompanied by Considine, left the hotel. "Traffic stopped," Considine said. "Pedestrians stopped. And they started clapping for her, just spontaneously, and the echo of the applause along the street was extraordinary." (Leader Post, News, Sept 2013)

Canadian Courts or Legal System Representatives

Canadian courts and legal system representatives made up 12% of *Freedom* hero characters, across 14 articles. These characters were applauded after MAID legalization as having taken an influential step in the right direction for human dignity, and as having an “uncanny” ability to make well-reasoned decisions that should be followed.

> If you read the court decision, it ably considered most of the concerns still being heard, dismissed them with excellent, logical thinking based on indisputable facts. It wasn't the least bit ideological, either. (The Times – Transcript, Opinion, June 2016)

General Canadian Public

10% of *Freedom* heroes, across twelve articles, were the general Canadian public who are more “savvy” and “open-minded” than their politicians, and who force politicians to address the subject of MAID and push for MAID-favourable policies.

> A Conservative MP who wants to legalize assisted suicide is appealing to unelected senators to prod elected MPs into a national debate on the right to die… "Canadians are demanding that this issue be dealt with," he said after the meeting. "The Canadian public is eons ahead of most parliamentarians on this issue." (National Post, News, May 2014)

Family and Friends of Prospective MAID Recipients

6% of *Freedom Camp* hero characters were family and friends framed as bravely supporting their loved one’s choice to pursue covert suicide pre-legalization or overt MAID post-legalization, described in warm, atmospherically descriptive terms. Family and friends were described as being ‘understanding’ of their loved one’s desire for suicide (solo or assisted) prior to MAID legalization, whether or not this involved wrestling with their own feelings about it. Family members and friends were sometimes described as supporting their loved one by providing them with extra attention before receiving MAID and trying to make the MAID experience a positive and pleasant one. In one narrative this included helping shield the patient from others who opposed the procedure, contrasting heroically-framed family members with villainously-framed ones based on their support for, or opposition to, MAID.

> Then the phone rang. The evangelical minister of her sister-in-law's church. "Don't pick up, don't pick up," we all surrounded her, but still his voice came on the speakerphone as he laid down his words; "What you are doing today is a sin. You must stop this at once." We gathered in closer, singing You Are My Sunshine loudly to drown out the minister's voice, until we get to the part about "Lord, don't take my Sunshine away." Then we just hum, but his words still

> pierce the air, recorded now forever more: "You must stop this at once." But that is what Beverly is doing. She's stopping this. Today. Stopping the pain, stopping the medical interventions, stopping the decline. . . . The phone rings, again, her evangelical sister-in-law now, pleading to save Beverly's soul, insisting she should instead suffer through these last days and weeks and months, until her Lord decides to take Beverly on his time. Her suffering, her penance. For what? "Please stop," the sister-in-law says. "Did you get something to eat?" Beverly says, hanging up…. Her love is by her side, and will do what he has done every night for months to ease her into sleep. He will read her Winnie the Pooh, just like that, he will do as he has done every night, to send her into this never-ending slumber. (The Globe and Mail, Feature, July 2017)

Activists or Activist Organizations who Promote MAID

Another 6% of *Freedom* heroes were MAID activists: individuals or organizations, such as Dying With Dignity Canada, described by *Freedom* advocates as devoted to broadening end-of-life choices and improving the quality of death experience:

> I'd met Katherine when I was the CEO and she was a volunteer for Dying With Dignity, an organization dedicated to improving quality of dying, protecting end-of-life rights, and helping Canadians avoid unwanted suffering. (The Windsor Star, Opinion, Feb 2018)

Palliative Care Organizations

3% of *Freedom Camp* heroes were palliative care organizations, a hero-perspective shared by the other narrative camps, although *Freedom* narratives characterized palliative care systems as improvable by adding MAID to their range of practices:

> I began my medical career in the late 1970s in palliative care. I still believe it is the bedrock of good end-of-life care. Yet after reviewing the changes since then with respect to both how and why people die in industrial societies, I would side today with allowing people a choice. I applaud the careful thought and deliberation that has gone into creating a new set of options for people at the end of their lives. (Eagle Valley News, Letter, Mar 2016)

The Laws Themselves that Enable MAID

Another 3% of the *Freedom Camp* hero cast was framed to be MAID-enabling law itself, described as providing comfort to Canadians.

> Whatever the final parameters, the ruling will provide comfort to Canadians seeking a "humane and dignified" exit from this world, and in their own country, says the family of the woman behind the original lawsuit. (Leader Post, News, Feb 2015)

MAID Itself

2% of the *Freedom Camp* hero cast was the MAID procedure itself. Naturally, MAID was also implicitly heroized in many more *Freedom* narratives. However, in a few stories the MAID procedure (especially the lethal injection method) was explicitly heroized rather than the law permitting MAID or the person performing MAID. In these narratives, MAID was framed in standalone terms as the benevolent "gentle exit" that will relieve suffering, and save Canada millions of dollars annually by avoiding costly end-of-life care:

> If Canada follows the experience in the Netherlands and Belgium, the researchers estimate medical assistance in dying will eventually play a role in one to four per cent of all deaths in Canada. At the high end, that would be 10,722 deaths a year, they calculate. Overall, they estimate medical assistance in dying could reduce annual health spending by $35 million to $139 million, exceeding the $1.5 million to $15 million in direct costs. (The Province, News, Jan 2017)

Professional in Other Category

Finally, in one article the *Freedom Camp* cast as hero Russell Ogden, a university researcher in sociology, who performed what *Freedom* advocates described as "groundbreaking" research into "Nu Tech deathing" when suicide assistance was still illegal in Canada.

> For more than 14 years, Ogden has engaged in controversial and groundbreaking research into scores of underground assisted suicides (often known as "Nu Tech deathing") by people dealing with AIDS, cancer and other terminal illnesses. (Leader Post, News, July 2008)

Moral of the Story (According to *Freedom Camp* Policy Narratives)

Freedom story morals (that is, propositions from the *Freedom* narrative perspective about "what should happen") occurred in 167 documents (56% of documents). According to *Freedom Camp* narratives, in descending order of frequency:

	Something should be done about…	Pg.
25%	Baseline Legal Activity	74
15%	Access Categories	75
10%	Conscientious Objection Rights	75
6%	Political Activity	76
6%	Patient Experience	77
5%	Other Rights	77
5%	Discourse	78
5%	Health Workers	78
5%	Safeguards	79
3%	Deference due Courts	80
3%	Deference due Government	80
2%	Morals or Culture	81
2%	Money or Resources	81
2%	Healthcare System	82
1%	Deference due *Elected* Officials	82
1%	Activism	83
1%	Oversight	83
1%	Religion	84

Baseline Legal Activity

25% of *Freedom Camp* story morals explicitly advocated that suicide assistance and/or active + direct euthanasia should be decriminalized and/or legally regulated in Canada. (In all narratives categorized as belonging to the *Freedom Camp,* this story moral was at least implicitly present; this code category indicates explicit examples.) A small minority of *Freedom* arguments about baseline legal activity advocated legal limbo rather than legal regulation, similar to the lack of any replacement law regulating abortion in Canada after its decriminalization in 1988. Others advocated for an opt-in system of legal documents that go beyond the current scope of living wills, such as documents categorically refusing MAID or categorically insisting upon MAID:

> There's a growing consensus that euthanasia is a victimless crime crying out for an end to Criminal Code consequences for doctors assisting in a life-ending procedure. In a world where everyone seems intent on protecting human rights for the living, there's considerable irony in politicians again rejecting a humane right to die. (National Post, Opinion, Oct 2009)

Categories of Access to MAID

The second most popular *Freedom Camp* story moral, at 15% of *Freedom* story morals, was about whether access to MAID should be expanded or kept limited. *Freedom Camp* story morals advocated categories of expansion rather than limitation of access, in all but one article: expansion to persons whose death is *not* otherwise “reasonably foreseeable” (25 documents); expansion to enable “advance directives” to have MAID performed when no longer capable of informed consent (15 documents); expansion to minors (13 documents); expansion to the mentally ill (11 documents); expansion to the permanently unconscious (i.e. coma) or to romantic partners who request a simultaneous procedure (1 or 2 documents each). In the one article wherein a *Freedom* advocate advocated access limitations, these were proposed for children and the mentally ill. Here is a typical example of *Freedom Camp* advocacy for expanding access to the mentally ill:

> … ethicists have argued competent people struggling with severe depression or other mental disorders should be treated no differently than competent people suffering from incurable, physical ones… "This isn't about what organized religions or palliative-care doctors or other physicians want," said Vancouver psychiatrist Dr. Derryck Smith, a professor emeritus at the University of British Columbia and physician adviser to Dying with Dignity Canada. "Psychiatric illness is simply a disorder of the brain - it's another part of the body." If the person is competent, "I would see no reason why we should not go ahead and grant their wishes," he said. (The Province, News, Sept 2015)

Conscientious Objection Rights

In 10% of *Freedom* story morals, an argument was made about conscientious objection rights – whether of individuals or institutions – mostly arguing against conscientious objection rights or to restrict their scope. A plurality of articles advocated that healthcare practitioners should be legally or professionally obligated to refer for MAID (14 documents). Several story morals argued that conscientious objection shouldn't exist at the institutional level and MAID must be performed within all healthcare environments, including Catholic hospitals and Jewish care homes (8 documents). Three articles advocated that doctors should be forbidden conscientious objection rights because "patient rights trump doctor rights." Two articles argued that conscientious objection at the institutional level should lead to a loss of public funding. Two articles argued that doctors must at least designate a staff member to refer for MAID, and one argued that institutions should refer for MAID. One article argued that a doctor must at least advise a patient that one of their options is MAID. And finally, – going against the grain of *Freedom* narratives – one otherwise *Freedom*-voiced article argued that an alternative mechanism, such as a website resource or institutional ombudsman, should be provided to bypass the need for physician referrals.

> But, in the rare instances where the values and beliefs of patients and physicians clash, it has to be abundantly clear that patient need takes precedence over physician discomfort, and <u>patient rights trump physician rights</u>. As the CPSO says, "The fiduciary nature of the physician patient relationship requires that physicians prioritize patient interests" - even when a patient chooses to die. (The Globe and Mail, Opinion, Feb 2016)

Political Activity

6% of *Freedom-framed* story morals, across 17 articles, argued that something should be done about political activity. Eight articles proposed that whatever government or politicians do, they mustn't overrule courts and must respect court-defined 'rights'. Six articles argued that the post-decriminalization government panel, tasked with running consultations about how to implement MAID safely and effectively, should remove members who had served as government court witnesses opposing MAID's legalization, because they may give the panel an appearance of bias. Other articles advocated for a variety of "should" statements about politicians, from encouraging people to lobby MPs to support MAID, to stating that politicians should be allowed 'free' votes without partisan pressure. Interestingly, in contrast to other post-decriminalization *Freedom* narratives emphasizing deference to courts, one post-legalization *Freedom* narrative characterized the government's pre-2015 deference to courts as "misguided":

> "The last government spent millions in taxpayers' money to defend, unsuccessfully, a law that caused immeasurable suffering and, in the process, ran roughshod over Canadians' charter rights," said Shanaaz Gokool, CEO of Dying with Dignity Canada. "We question why the current government, with its stated commitment to upholding the charter, would want to adopt the same misguided approach." (Chronicle – Herald, News, Sep 2016)

Patient Experience

6% of *Freedom Camp* narratives, across sixteen articles, argued for improvements in patient experience. Eleven articles supported more convenient MAID access by ensuring MAID is available locally and at the location of an individual's choosing, with no need to be transferred. One article advocated that those who choose MAID should be permitted to donate their organs, (arguably improving an experience by respecting their wishes). One article advocated for improving palliative care while legalizing euthanasia, linking the quality of the patient experience with improved palliative care. And one unusual *Freedom* article featured a man paralyzed from the neck down, who once planned to withdraw his treatment but later changed his mind and found his life improve. He expressed mild support for MAID legalization in restricted cases, but argued that more priority should be placed on improving life experiences by freeing people from CHSLDs (the acronym for long-term care facilities in Quebec).

> It would be the "height of indignity" for a suffering person to be forced to leave a hospital to seek a physician- assisted death, said Shanaaz Gokool, CEO of Dying With Dignity, which applauds the 21 recommendations released by a parliamentary committee examining what provisions a right-to-die law should include. An important recommendation requires all publicly funded hospitals, hospices and other health institutions to provide physician-assisted dying, said Gokool. . . . "From our perspective there is great harm when a hospital decides it's going to abandon people at their most desperate time of need." (The Windsor Star, News, Mar 2016)

Other Rights (apart from Conscientious Objection)

5% of *Freedom* story morals, across 15 articles, argued that something should be done about rights *other* than conscientious objection rights. A narrative element was coded here if it explicitly used the language of 'rights'. The vast majority were calls for the 'right to choose [MAID]'. One article, referencing the *Carter* decision, alluded to other rights like the rights to life, liberty, and security, arguing these rights are violated when suicide assistance is a criminal offence.

> It is a stunning judgment - and also a welcome one. <u>The ability to cut short an existence characterized only by suffering and sorrow should be regarded as nothing less than a fundamental human right.</u> The Supreme Court is to be applauded for vindicating it so forcefully and unambiguously. (National Post, Opinion, Feb 2015)

Discourse (Words and Conversation)

5% of *Freedom Camp* story morals advocated for something to be done about discourse. Most frequently, this involved advocating to avoid words deemed stigmatizing (e.g. "suicide", "euthanasia", "edict"). Other story morals advocated for the public and politicians to talk more about MAID. Three articles encouraged the public and doctors' organizations to treat legalization as inevitable and move past the yes/no debate to specifics of the 'yes'.

> "It seems clear that physician-assisted death will become legal in Canada in the very near future by one means or another," said Downar, a Toronto doctor who cares for the terminally ill. "And we felt that Canadians would be better served if the <u>debate</u> were to <u>shift to more practical considerations</u> about what that might look like." (Moose Jaw Times Herald, News, Apr 2014)

Frontline Healthcare Practitioners (beyond Conscientious Objection)

5% of *Freedom* story morals, across 14 articles, advocated that something should be done about frontline healthcare practitioners beyond addressing conscientious objection rights, which would otherwise have occupied the bulk of this coding category. Four articles argued that doctors need more specialized training, assistance through ethical dilemmas, and reassurance that they won't be punished after the fact for "acting in good faith." Two articles argued that doctors should 'toughen up' and stop opposing euthanasia, and that palliative caregivers should stop "fighting against" MAID. One article vaguely advocated that doctors should "help people over the step… without any words ever being said by the family." One article argued that a physician should not be legally required to be so 'disrespectful' as to ask a person to reaffirm their consent to die immediately prior to the fatal injection.

One article argued that doctors need to become more comfortable talking about death, and stop sugar coating prognoses. One article argued that "there need to be more doctors willing to perform assisted deaths." One article argued that nurses – not just doctors – should be able to administer MAID. And one article argued (in a court scenario) that the names of doctors who perform MAID must be kept anonymous, so as to "ensure health workers keep helping out in such cases." One article argued that doctors should be assisted to focus on their work rather than on bureaucratic processes associated with MAID; this article also argued for increasing financial compensation for physicians who perform MAID.

> MAID should never be taken lightly, but it is hard to believe patients are better served by turning doctors into form-fillers than by ensuring they have the support to carry out the critical and emotionally draining work of journeying with a patient through an assisted death. Yet across Canada, doctors are paid considerably less than half of the fees they could earn doing simpler, less taxing procedures in their office. In some cases, they receive less than a veterinarian charges to put an ailing poodle to sleep… While we cannot hope to compensate doctors for the emotional toll of providing such a critical service, we must at least compensate them fairly for their time. (Star – Phoenix, Opinion, Aug 2017)

Safeguards

5% of *Freedom* story morals, across 14 articles, argued that something should be done about safeguards. A slim majority of these advocated against specific safeguards: 5 articles advocated *against* requiring a psychiatric assessment before MAID; one article advocated to eliminate the 10-day waiting period between initial MAID request and MAID; one article advocated against requiring consent to be re-affirmed immediately before MAID is performed. In contrast, 6 *Freedom* articles expressed vague and generic support for at least the *concept* of "safeguards" or "protection" for the vulnerable. That is, they argued that "safeguards" or "protection" should be developed by whoever's area of expertise that is, though these narratives didn't propose any *specific* safeguards. And finally, one *Freedom* article drew a firm and specific line in arguing that a necessary safeguard against abuse was to “exclude children” from accessing MAID.

> Others say it's unfair to cast psychiatrists in the role of "gatekeepers," or to force every person exercising his or her legal right to a doctor-assisted death to undergo a mental evaluation. Mandatory assessments, several prominent U.S. psychiatrists wrote in 2012 in The Hastings Report, would turn the consulting psychiatrist "into a secular priest dressed in the clothes of a medical expert." Others argue the issue is about patient autonomy. (The Vancouver Sun, News, Sep 2015)

Deference due Courts and Law

3% of *Freedom* story morals advocated that something should be done about the deference due to courts and law. *Freedom* excerpts that advocated something explicit about the deference due to courts almost unanimously argued (once suicide assistance was decriminalized) that government officials and all Canadians must abide by what courts declare, and shouldn’t try to interpret the court’s decision in any way that might fail to fully comply with the court’s intention.

> It isn't the job of the committee and government to find ways to somehow limit or lessen either the intent or spirit of the SCOC ruling. The court has spoken; it merits respect. Nor are there grounds for genuine confusion over what it meant. The full decision is on the SCOC website: it's well argued and thorough; it makes the principles behind its decision clear… Finally, there are many details and choices to be made, but let's not get bogged down. Some are already presenting these as horribly difficult. Should a physician be present at a physician-assisted death, or should we allow them to prescribe a lethal cocktail the patient can possess and administer when they deem the time is right, as occurs elsewhere? This is an unnecessary debate. Both are doctor-assisted dying and both fall well within what the public considers acceptable and desirable. To rule out options that fall within the intent of the SCOC ruling is to disrespect the ruling and the public's rights. (The Times – Transcript, Opinion, Feb 2016)

Deference due Government in General

3% of *Freedom* story morals advocated that something should be done about respect and obedience for government in general**.** This manifested as an expression of the deference that government is *not* due: the belief that government should respect and obey the courts and the will of the people, instead of the other way around.

> Paterson said all governments must respect the Supreme Court's February ruling, which recognized the right of clearly consenting adults who endure intolerable physical or mental suffering who wish to end their lives with a doctor's help. "Canadians overwhelmingly support

> the right to physician-assisted dying, and it is the law of the land," he said." Whatever advice this panel might provide, it is clear that Parliament must not enact a law that creates barriers for those who wish to access their constitutional right to physician-assisted dying." (Telegraph-Journal, News, July 2015)

Morals and Culture

2% of *Freedom* story morals seemed best categorized as arguments about what to perceive as correct values and culture. 5 articles emphasized the notion of "freedom to choose" assisted suicide or active + direct euthanasia as a standalone cultural good. Three of these articles asserted that no matter how good care is, "freedom" to choose the timing of one's death by MAID would still be necessary for the sake of freedom itself. Three other articles asserted that it is bad to "stay and suffer" and good to "cut short an existence characterized only by suffering and sorrow." One article proposed that in a multicultural society, assisted suicide should be publicly respected and interpreted as one among many different kinds of courageous act.

> But this country is a mosaic of beliefs and viewpoints, and so we must respect that some people will consider assisted suicide in extreme cases, and that this is also a form of courage. (Montreal Gazette, Opinion, June 2016)

Money and Resources

2% of *Freedom* story morals argued that something should be done about money and resources. Four articles argued for various expenditures to be reduced. Two argued for people to stop donating to institutions that fail to perform MAID. One argued that government shouldn't waste money or time on committee hearings to sort through safeguard concerns when (in the narrator's opinion) concerned individuals could just protect themselves by putting their blanket refusal of MAID in writing. One article suggested that finite resources shouldn't be wasted on a person whose body has become an "empty husk." In contrast, two articles advocated increasing expenditures: one advocated sending money to Dying with Dignity Canada to promote their efforts to lobby for decriminalized

MAID, and one advocated for doctors to receive increased financial compensation for the time they spend performing MAID.

> A word of caution: Make sure your chosen charity aligns with your values. Many social service organizations have a religious affiliation, and they're not always up front about it… A hospital or hospice may refuse to allow patients to exercise their right to an assisted death… If this doesn't align with your values, steer your donation dollars elsewhere. (Leader Post, Opinion, Dec 2017)

System-Level Healthcare Organizations

2% of *Freedom* story morals, across six articles, argued that something should be done about system-level healthcare organizations beyond whether organizations should have conscientious objection rights. If narrative elements coded as related to conscientious objection had been included, it would have made up the bulk of this category; see the 'Conscientious Objection' section for details. Remaining *Freedom Camp* story morals about system-level healthcare organizations were few and varied. These included: two articles arguing that palliative or hospice care institutions should provide MAID; one article arguing that bureaucratic processes and paperwork need to be systematically streamlined; one article arguing that the CMA should be at the table to "help draft a new law and guidelines for physicians and patients"; one article arguing for a "uniquely Canadian" approach to MAID that would avoid existing institutions and involve creating new end-of-life clinics; and one article arguing that "of course" palliative care must be improved, but MAID will still be necessary.

> Quebec Health Minister Gaetan Barrette, a doctor himself, says the refusal by the province's hospices to provide the procedure amounts to "administrative fundamentalism".... Some in Quebec want the provincial government to take a hard line on the holdout health-care establishments. They note that while the hospices are privately run and thus not obliged to follow the law, some still receive a level of provincial funding. . . "That an institution in a secular state which receives funding from the public and (donations) from the general public would impose such a decision, I find it scandalous," said Helene Bolduc, founding president of the Quebec Association for the Right to Die with Dignity. (Toronto Star, News, Sep 2015)

Deference due *Elected* Officials

1% of *Freedom* story morals advocated about respect or obedience due to elected officials, but disagreed amongst themselves on this matter. One article argued that the final say in a law-making matter should always go to Canada's elected representatives. Another article argued that elected officials in government should be required to accept the influence of unelected senators. Another two articles emphasized that whatever the relationship between elected and unelected representatives, laws in a democracy should ultimately reflect the will of the popular majority, not so-called 'experts' with whom government officials consult.

> Bill C-14 passes the test of being a reasonable response by the House of Commons to the court's ruling. That is the other reason why the Senate must now vote it into law. The Senate has done its job. It forced both the Commons and the public to reconsider this issue, and it proposed amendments - most of which the House has incorporated. But the final say must always go to the elected chamber. It is our elected representatives who make laws in Canada, not our unelected ones. (The Globe and Mail, Editorial, June 2016)

Activism

1% of *Freedom Camp* story morals encouraged Canadians to participate in pro-MAID political lobbying with their MPs, and to support the Dying with Dignity Canada organization.

> He said he supports the most recent recommendations of the federal committee drafting the new law and encourages Vancouver Islanders to lobby their MPs directly and through the website dyingwithdignity.ca to see them adopted. (The Courtenay Comox Valley Record, Opinion, Mar 2016)

Oversight

1% of *Freedom* story morals promoted oversight of MAID in calling for collection and transparent reporting of data so as to identify, for example, the reason why certain requests may not ultimately lead to MAID.

> That isn't the number Shanaaz Gokool, chief executive officer of Dying with Dignity Canada, finds most troubling. "My real concern would be the number of people who've died before their request has been fulfilled," Gokool said. "There just isn't enough data to say why."… Gokool said her organization wants to know how many are dying unassisted because they've lost the mental capacity to make a final decision or because the process itself is taking too long. If the latter, it could be an indication there aren't enough health-care providers engaged in the process. (Winnipeg Free Press, News, Oct 2017)

Religion

And finally, 1% of *Freedom* story morals suggested, at least implicitly, that something should be done about religion. In one article this involved arguing that religious views shouldn't be imposed on people outside that religion. Another article suggested that a religion's views shouldn't even be applied to its own followers, for instance in regard to religious burial rituals:

> I am saddened and confused to learn that leaders in some parts of the Roman Catholic Church vent their disapproval of what is the law in Canada by turning on their own… we discover that certain bishops in Western Canada deem it appropriate to deny a Roman Catholic from receiving a Christian burial in a Catholic service in the circumstances where "church authorities" discover that a deceased has availed him/herself of a medically assisted departure. (National Post, Letter, Oct 2016)

Narrative Strategy (in Freedom Camp Policy Narratives)

The *Freedom Camp*'s narrative strategies included several frequently recurring components, four of which will be mentioned here. These were: framing euthanasia legalization as a 'sticky slope' rather than a 'slippery slope'; using a strategic tone of limitation-reassurance (or after legalization, a tone of expansionist urgency); conceptually blurring lines as a rhetorical technique to persuade readers to accept an activity; and associating euthanasia legalization with other "progressive" trends the reader seemed implicitly expected to already view positively.

Sticky Slope

Particularly during the earlier years sampled, *Freedom* Camp narratives made heavy use of what I'll call "sticky slope" rhetoric as a narrative strategy. Whereas "slippery slope" is the name of a logical fallacy in which an action is predicted – without logical justification – to lead to an unwanted cascade of events, *Freedom* narratives often framed the legalization of MAID as a sticky slope, i.e., carrying no risk of unwanted effects. Not all examples of the sticky slope narrative strategy actually referenced the words "slippery slope," though many did; variations of 'sticky slope' narration included various forms of suggestion that euthanasia applied in one situation has no implications for euthanasia in another situation.

> Prohibitionists against euthanasia remain adamant that the Liberal proposal leads to an "anything goes" mentality. They insist that once assisted suicide has been transformed from a crime into a public service, grounds to limit that right to some sufferers and not to others disappear. According to this logic, if the grievously ill are permitted an early exit, the next step will be physician-assisted death for broken arms, bad breath and hangnails. Fortunately, the courts possess an uncanny ability to distinguish between constitutional rights and frivolous claims. Bill C-14… does not represent [ ] the relativist nightmare dreamed up by slippery slope crusaders. (Winnipeg Free Press, Opinion, Apr 2016)

Relatedly, the *Freedom Camp* frequently framed MAID as an activity that, as one article put it, "only holds implications for a single life." These articles argued that MAID should be understood as occurring in isolation and without implications or ripple effects, rather than as part of any larger system of activities that may affect others. For example:

> Another concern about assisted suicide is that the practice delegitimizes the lives of the disabled. If people choose death over debilitation and dependence, some ask, what does that say about our attitude toward those who live their entire lives debilitated and dependant? Wouldn't legalizing assisted suicide, they suggest, tell the disabled that their lives are not worth living? At the risk of sounding rude, I find this argument overdramatic. Assisted suicide is one choice among a large variety of options, none of them objectively better than the others. We all have different viewpoints and live in drastically different personal contexts. A person's decision to end his or her life only holds implications for a single life: their own. (Montreal Gazette, Opinion, June 2016)

Strategic Tone

The *Freedom Camp* strategically adopted various narrative tones. After the tone of fear (e.g. fear of suffering), this included tones of: inevitability; limitation-reassurance (common prior to decriminalization); and expansionist-urgency (common after decriminalization).

Inevitability:

> The wave of reform, driven by millions of anguished personal experiences in families across Canada, is coming. It's a matter of when, not if. It's difficult to imagine any subject more worthy of a national debate, at the highest level, than this. (The Ottawa Citizen, Opinion, Feb 2015)

Reassurance:

> Sadly, a minority of individuals with disability have said the Supreme Court ruling makes their life worthless. Nothing could be further from the truth… If a person is not cognitive, say, with dementia, they would not be eligible for physician assisted death. Nor, to give another example, is an individual with chronic depression. (Whitehorse Star, Letter, June 2015)

Expansionist Urgency:

> Fortunately the Supreme Court of Canada has finally allowed doctor-assisted death… But politicians have encumbered the law with cruel restrictions that boggle the mind, resulting in a double standard of justice. They've forbidden the advanced directive. This means that patients suffering from early stages of Alzheimer's Disease, or other forms of dementia, cannot state their wishes about eventual death while mentally able to make this choice. But how can they do so later when not mentally sound? What a tragic decision at a time when an advanced directive is most needed. (Niagara This Week, Opinion, Sept 2016)

Conceptual Line-Blurring

A second prominent narrative strategy in *Freedom Camp* narratives was the conceptual blurring of lines between categories, suggesting murkiness or confusion about where to draw lines and how to help patients, or arguing that the difference between practices is merely 'aesthetic' or linguistic, and only perceived as 'different' or morally significant by ignorant people. *Freedom* advocates strategically proposed that if a reader believes one category of practice should be permitted, then they should agree that another practice – framed as categorically indistinct from the first – should be permitted.

> The government's initiative addresses previous gaps in end-of-life care options. One of the most important of these involves erasing the moral distinction between omissions and acts. Previous to the Carter v. Canada case, omissions were considered a viable option for the terminally ill. Once treatment was withdrawn or withheld, the patient's death was attributed to some underlying condition, such as a disease or trauma. However, in the case of euthanasia and assisted suicide, the patient dies as a result of the actions of a third party, the one who provides or administers a fatal drug. Omissions were considered part of standard medical practice, whereas positive acts were considered criminal. This moral distinction between omissions and acts has now evaporated**.** Since passive measures have the effect of hastening death, it is only rational to allow dying patients access to prescribed overdoses or lethal injections. (Winnipeg Free Press, Opinion, Apr 2016)

Trend Association

A third prominent narrative strategy in *Freedom Camp* narratives was trend association. That is, drawing conceptual connections for the reader between active + direct euthanasia and other trends or practices presumed to already have the reader's approval. The two most prominent trend associations that recurred were 'Vets Kill Pets' and 'Progressive Policies Already Passed.'

Vets Kill Pets:

> "I don't know how any sensible person can't believe in an assisted death if their life isn't worthy of living… When animals are suffering, we put them down. Why don't we do the same for humans?" (Toronto Star, Feature, Oct 2012)

Other Progressive Policies Already Passed:

> "I am so proud of Canada for being such a progressive nation - we've accepted divorce, abortion and same-sex marriage," Morcos wrote in his farewell letter. "It is now time for us to do the humane thing and embrace choice for the terminally ill to have medical assistance to end their life when it has become unbearable. (The Spectator, Feature, Sept 2012)

Reframing of Conversational Language

A fourth prominent narrative strategy employed in *Freedom Camp* narratives (explicitly promoted as such by Dying With Dignity Canada's representatives) was to encourage the reframing of "conversational language" about MAID, especially avoiding words deemed stigmatizing due to cultural connotations of mental illness or criminality, e.g. 'suicide' or 'euthanasia.' While many *Freedom* articles did reference the mechanical reality of a MAID procedure by concretely referential language such as 'lethal injection', many *Freedom* narratives omitted direct reference to the procedure's characteristic feature of killing of a body, instead framing MAID as a procedure whose characteristic feature is killing pain, or taking back control from a disease, or simply ceasing to fight or ceasing to decline, or having assistance so that an experience of suffering ends, or a life ends (without the precise manner of ending spelled out).

> One point of clarification. The article mentioned that the Supreme Court is "studying the constitutionality of the existing ban on assisted suicide." This is where conversational language is so extremely important. Assisted suicide is wrong and should remain a criminal offence. Suicide is an act of desperation by people who are, at that moment, mentally unable to see a solution to their situation. They are not physically ill, nor are they dying. They need help to live. But terminally ill patients at the end of their lives should have the choice to have assistance to end their suffering, whether that is physical, as in the case of many cancers, or the psychological pain that comes with ALS or other neurological illnesses… Sheilia Sperry, provincial co-ordinator, Dying with Dignity (Chronicle – Herald, Letter, Dec 2014)

Chapter 5: *Protection* Camp Policy Narratives

The *Protection* policy narrative camp opposes baseline decriminalization of suicide assistance or active + direct euthanasia. Narrative elements were assigned to this camp when the associated narrative expressed explicit opposition to the baseline legalization of suicide assistance and/or active + direct euthanasia. Originally labelled the 'Pro Assisted Life' (PAL) camp, I subsequently renamed the camp to avoid using either an unwieldly three-word label time after time, or an acronym the memorization of which a reader might find distracting. I chose to rename this policy narrative camp '*Protection'* because of the typical emphasis of MAID-opposing narratives on 'protection' as a bottom line value undergirding their arguments – whether protecting the vulnerable from harm, protecting a value (e.g. sanctity of life), or protecting health workers from pressure towards violation of conscience. Such an underlying drive for 'protection' was expressed, for example, in media excerpts such as (emphases mine):

> We were brought together by a common mission: to respect the sanctity of human life, which is a gift of God; to protect the vulnerable; and to promote the ability of individuals and institutions to provide health care without being forced to compromise their moral convictions… It is essential that the government ensure that effective conscience protection is given to health care providers. (The Ottawa Citizen, Press Release, Feb 2016)

This chapter analyzes the *Protection Camp* narrative policy position. It examines the *Protection*-framed setting, characters, moral of the story (i.e., preferred policy), and most prominent narrative strategies employed by the *Protection Camp*. Category-representing media examples with underlined emphases are included. As shorthand, I refer to *Protection Camp* policy advocates as *Protectors*.

Setting (According to Protection Camp Policy Narratives)

Protection Camp policy narratives collectively describe the setting of this story as:

1. Socially composed of compassionate people on both 'sides' of this debate;

2. One in which existing end-of-life care is already effective and enables dignity;

3. One in which real inequities of access to good end-of-life care exist and need to be addressed;

4. One in which distinctions between practices are significant, not just nominal;

5. One in which foreign jurisdictions set precedent we *shouldn't* follow;

6. One in which lawmakers have shrugged off institutional constraints on their power; and

7. One in which Canadian health workers overwhelming want the right to opt out of any participation in legalized killing.

Details and media examples follow.

1. Social Parallel between Compassionate People on Both Sides

According to *Protection Camp* policy narratives, we live in a world where everyone wants to live and die with dignity, and everyone wants to help others to live and die with dignity.

> There are many strong opinions on both sides but <u>both sides seem to have a lot of compassion for loved ones they have witnessed suffering</u>. They <u>all have a strong desire for a dignified death for their loved ones and for themselves</u>. The main difference, I observed, is the pro-euthanasia group supports laws that ultimately lead to killing. (The Windsor Star, Letter, Feb 2016)

2. End-of-life Care Can Already Enable Dignified Dying

Protectors describe 21st century Canada as a setting where death can already be comfortable and dignified, with effective pain management and palliative cares centres of excellence available as examples to replicate. Canadians were described as probably not sufficiently familiar with end-of-life care to be aware of these possibilities.

> The Windsor registered nurse, who was instrumental in founding Hospice of Windsor and Essex County's clinical and volunteer programs, believes support for the right-to-die law is motivated by fear… She said most Canadians don't understand <u>how dignified death can be when pain and symptoms are well managed</u>. (The Windsor Star, News, Mar 2016)

3. Real Inequities of Access to End-of-life Care Are the More Urgent Issue

Protectors frequently described the setting as one in which the urgent need is for reducing inequities (e.g. economic, geographic) in access to high quality supported life or end-of-life care.

> Earlier this month a handicapped woman as well as a coalition of physicians said they wanted to obtain an injunction to block the law… They also say a patient's consent cannot be free and informed if he or she has not been offered all palliative care options, which is not always the

> case in the province due to a lack of accessibility to certain treatments, drugs and services. (The Record, News, Nov 2015)

4. Differences between Practices are Significant, Not Merely Labels

Protectors describe differences between end of life choices (i.e. accepting death vs. actively + directly killing) as real and really mattering – not just a matter of aesthetics or labels

> "When people say there is no difference between sedating somebody and euthanizing them, I think they haven't worked enough with dying patients - because people who do know there is a difference," says Dr. Manuel Borod, director of the supportive-and palliative care programs at McGill University Health Centre in Montreal… With palliative sedation, people sleep until they die, which can take up to a week. Euthanasia involves an injection of barbiturates that abruptly kills. (Star – Phoenix, News, Jan 2015)

5. Foreign Jurisdictions have Set Precedents We Shouldn't Follow

Protection Camp narratives present foreign jurisdictions as sources of evidence that legalization of suicide assistance or active + direct euthanasia is inevitably unsafe and negative. This frequently involved listing statistics (e.g. rates of euthanasia carried out without adhering to legal guidelines, or demographics of those who receive MAID), often describing the 'human face' of particular cases.

> Simona De Moor was a fit 85-year-old…. But after her beloved daughter died this year, the grief was unbearable and she immediately decided she wanted to take advantage of Belgium's euthanasia law. Three months later, as an Australian documentary crew filmed, Dr. Marc Van Hoey gave her a glass of lethal syrup to drink… the DeMoor case is being held up to Canada as an example of the dangers of legalizing physician-assisted death… the law has led to the euthanasia of people suffering from severe depression... "…It is no longer controlled. People say that euthanasia is the best way to die. The media say, look, he is having a glass of champagne with his children, and then the doctor arrives and kills him. It is the trivialization that is very dangerous." Van Hoey… was frank about the flexibility of Belgium's euthanasia law, saying it was possible to skirt the requirement for a written request from the patient. He also acknowledged having helped a 56-year-old stroke victim who had been refused euthanasia obtain drugs to commit suicide. (Leader Post, News, Oct 2015)

6. Law-makers Have Shrugged Off Institutional Constraints on Their Power

Protectors describe the political-legal setting differently depending on date of publication. Prior to 2015, they frame the legal-historical setting as a reasonable one in which the 1993 Supreme Court had declared the ban against suicide assistance to be consistent with Charter Rights. After the 2015 Supreme Court flip to decriminalizing suicide assistance, *Protectors* describe the political-legal setting as one in which law-making institutions have become corrupted: inappropriately activist in asserting the wills of office holders without regard for institutional constraints meant to 'check' individual power.

> The dust is still settling from last week's historic ruling of the Supreme Court in the matter of euthanasia. One early casualty: judicial restraint, the fading notion that the courts, in interpreting the law, should be bound by something - the written text, the historical record, precedent, logical consistency. One by one, the court in recent years has liberated itself from these constraints; with the legalization of "assisted death," it has slipped free altogether. … What makes a decision "activist," then, is… whether the grounds for the decision can in fact be found in a sensible reading of the Constitution, or whether the court made it up… It's the absence, all too often, of any rational basis for its rulings - the sometimes cheery disregard for the whole concept - that is beginning to become alarming… As for the euthanasia decision: what can one say about a ruling that finds a right to death in a section of the constitution devoted to the right to life - that does so in breezy defiance, not just of Parliament's stated preferences, but of the court's own ruling in a similar case, rendered two decades before? The court goes to elaborate and unconvincing lengths to suggest it had been moved by changes in "the matrix of legislative and social facts" since then. The reality, one suspects, is rather simpler. It did it because it wanted to. (The Ottawa Citizen, Opinion, Feb 2015)

7. Health Workers Overwhelmingly Want Protection to Avoid Participation in MAID

Protectors emphasized conference votes and survey results demonstrating the desire of health workers for protection from pressure to participate in MAID.

> Most Canadian doctors appear reluctant to help end a life… Overall, the online survey of 1,047 doctors in June and July found 29 per cent said they would consider providing "medical aid in dying" if requested by a patient; 63 per cent would refuse… The nearly 300 delegates at the conference spent half the day Tuesday debating such questions as… whether doctors have a "carte blanche" right to refuse to play any role in any aspect of assisted dying, including referring patients to another, non-objecting doctor willing to help them die. The online survey asked: if a physician refuses to provide medical aid in dying, what should they be required to do? The most popular response was, "They should not be required to do anything." (Montreal Gazette, News, Aug 2015)

Cast of Characters (According to *Protection Camp* Policy Narratives)

110 documents (37% of documents) contained *Protection* characterization: that is, at least one appearance per document of at least one *Protection*-framed victim, villain, or hero. *Protection*-framed victims appeared in 98 documents (32.7% of documents); *Protection*-framed villains appeared in 48 documents (16% of documents); and *Protection*-framed heroes occurred in 30 documents (10% of documents). Of all *Protection* characters, 56% were victims, 27% were villains, and 17% were heroes.

Victims	Pg.	Villains	Pg.	Heroes	Pg.
54% Vulnerable Patient….	92	22% Discourse………..	95	26% General Public…...	100
24%Health Workers……..	93	18% Laws and Policies…	96	18% Health Workers…	100
11% General Public……..	93	11% Country…………..	96	15% Country…………	101
5% Healthcare System……	94	9% Background Situation	97	13% Religion…………	101
3% Family or Friends……	94	7% Health Workers……	97	10% Advocates……….	102
2% Misc. Specific………..	94	7% Ignorance…………	98	8% Health System…..	102
1% Still-Criminal (ironic)…	95	5% Healthcare System…	98	5% Family/Friends….	102
		5% Activists…………..	98	5% Law/Policy………	103
		5% "Those who…".........	99		
		5% Court, Judge………	99		
		3% Religious Lax……….	99		
		3% Misc. Specific……….	100		

Victims (According to *Protection Camp* Policy Narratives)

56% of the *Protection* story cast (appearing in 98 media articles) were victim characters. In descending order of frequency, victims as cast by the *Protection* narrative included:

The Vulnerable Patient

The primary victim of the story as told by the *Protection Camp* was the vulnerable patient, by a slim majority (54% of *Protection*-framed victim characters across 66 articles). This character was framed as exposed to unacceptable risk when MAID is legal. *Protectors* framed patients as victimized when allowed to feel hopeless, made to feel like an inconvenient or societally unvalued burden, or otherwise pressured towards choosing MAID. Specific vulnerable patient victims included: the mentally ill;

socially isolated; disabled (especially newly disabled who haven't yet adapted to their circumstances); children; cognitively compromised; rural poor; Indigenous youths; abuse victims; uncommunicative or non-consenting persons; foreign individuals euthanized for troubling reasons; and any individual who may be offered MAID to 'die well' *instead of* adequate support to 'live well'.

> "Many physicians and patients will find this a shocking prospect to consider," they write. "Frail, dependent patients often feel a burden to their families or caregivers, and the unspoken possibility of a quick resolution to their predicament may complicate an already stressful situation. Removing the legal barrier to ending another's life may ensure the self-dignity of those who wish to die, but may distress and remove the self-dignity of more people who wish to live." (The Vancouver Sun, News, June 2012)

Frontline Healthcare Practitioner

24% of *Protection*-framed victims were frontline healthcare practitioners who fear coercion against their conscience into MAID participation, or fear retaliation for conscientious objection, including possible loss of career.

> Little consideration is given to the "death squads," the doctors and nurses expected to deliver the deadly medication, she said… While it's expected legislation will include the right of health professionals to opt out for reasons of conscience, they may be required to refer patients to doctors willing to assist. "Whether I'm the executioner or I'm made to refer someone to an executioner, I feel I'm still responsible," said Burke, a physical rehabilitation specialist. He worries that if he follows his conscience he may contravene the rules of the Ontario College of Physicians and Surgeons and end up losing his licence. (The Windsor Star, News, Mar 2016)

The General Public or Society Itself

Protection Camp narratives framed the general public as 11% of their victim cast, suffering from: lack of widespread access to high quality palliative care; widespread loss of trust in health workers and care sites to defend and prioritize life when MAID is legal or forced upon care sites; a general devaluing of life, and values-shift to a more resigned and less courageous or creative approach to challenges; and misleading messaging that obscures the breadth of the MAID conversation.

> All the good work by palliative care providers could be badly damaged by how federal legislation legalizing medically-assisted death is implemented, warns Delta Hospice Society executive director Nancy Macey… She told the board many people put off seeking end of life support and the perception that medically assisted deaths would be carried out at palliative care facilities operated by groups like Delta Hospice would create even more trepidation, and even mistrust,

> which could erode programs. "People at home would avoid access to the program, which they already do, will not have 24-hour access to symptom management or caregivers to help transfer, toilet and bathe patients once they are in advanced stage of disease. We have seen caregiver burnout and emergency room visits where they will die or be admitted to acute care. Patients would occupy acute care beds because of fear of accessing hospice care," she said. (Delta Optimist, News, Oct 2016)

System-Level Healthcare Organizations

5% of *Protection Camp* victims were framed as being system-level healthcare institutions whose successful operation depends on charitable support from religious bodies, or which consider their guiding principles prohibitive of MAID, with operations at risk of defunding or ethical compromise if pressured to participate in MAID.

> Russ Tychonick does not seem to understand many publicly funded institutions, such as Concordia and St. Boniface Hospitals, also depend upon massive privately funded endowments to ensure their sustainability… The deliberate taking of a life, however, is obviously antithetical to their ethos of preserving life and providing humanitarian care for the suffering and dying. To force faith-based hospitals to perform "right to die" procedures in violation of their ethical codes would be, ironically, a breach of the very charter right invoked to pass Bill C-14 in the first place. (Winnipeg Free Press, Letter, Dec 2016)

Family and Friends of Those Who Die by Suicide

3% of *Protection* victims were framed as being the distressed left-behind family and friends of persons who die by suicide instead of receiving effective assistance with their needs.

> The retired schoolteacher did not have an incurable disease, nor was she in chronic pain. She wanted to die because she suffered from chronic depression. She found a psychiatrist who agreed. Her family was not informed in advance. Her son, Tom Mortier, found out about her death the next day when he was summoned to deal with the paperwork. Mr. Mortier is now a passionate opponent of Belgium's euthanasia law, which has been gradually broadened since it was introduced in 2002. (The Globe and Mail, Opinion, Feb 2014)

Professionals in Other Categories

2% of *Protection Camp* victims were professionals in other categories, including an anti-MAID ethicist put in the difficult position of implementing MAID policy, and a physician scholar framed as unfairly pressured out of a working group for a three-years-prior commentary.

> Dr. Harvey Schipper was judged harshly in some circles for having authored a commentary in 2014 in which, according to some reports, he had "compared arguments used to justify assisted

> dying with those advanced by Nazi Germany to justify the Holocaust." Schipper was repeatedly characterized as "a strident opponent of assisted dying" for reasons having nothing to do with the tone or substance of his argument. (The Times – Transcript, Opinion, June 2017)

Those Involved in Still-Criminalized Suicide Inducement

Finally, one *Protection*-framed victim (framed ironically as such for rhetorical effect) was a girl criminally convicted for (this article analogized) 'assisting' her boyfriend's suicide.

> Apparently, Carter not only failed to seek help for Roy, but actively encouraged him to carry out his suicide… Perhaps Carter mistook her boyfriend's apparent desire to die as his true desire? If it were his true desire, shouldn't he be allowed to do it - and enlist whatever help he needs? … If and when Canada begins to allow and possibly even pay for physician-assisted suicide, Michelle Carter may be watching from jail, wondering at the reward for her assistance. (National Post, Opinion, Mar 2015)

Villains (According to *Protection Camp* Policy Narratives)

27% of the *Protection* story cast (appearing in 48 media articles) were villain characters. In descending order of frequency, villains as cast by the *Protection* narrative included:

Cultural Discourse

22% of *Protection*-framed villains fell into the impersonal category of 'talk and ideas', or 'cultural discourse'. The most frequently villainized idea was framed as the 'distorted' idea that 'autonomy' or 'individual liberty' is worth any social cost, or is more valuable than inherent human dignity or life itself (*Protectors* sometimes critiqued the idea that 'pure' autonomy exists). Other discourse villains were: the false narrative that MAID is to relieve physical pain; the false narrative that dignity can be lost or means euthanasia instead of supportive care; the false idea that a 'death wish' should be taken at face value; the false narrative that faith-based hospitals discriminate against persons instead of between procedures; the 'death before disability' discourse that impacts persons with disabilities; the trivialization of MAID as the 'best way to die'; the court-sent message that some lives are not worth living; and the media's 'perversion' of language to rebrand killing under "respectable", "nice" language.

> Smith, a board member of Dying with Dignity, testified that Bill C-14's safeguards, designed to help protect the lives of people like us, were just too troublesome. Smith made his biases and

> ableism clear: in describing physical and mental ailments, he said, "I don't want to live like that." In other words, "If I was like you, I'd rather be dead." What the doctor thought of us was very clear... Smith spoke crassly about wanting to make an advance directive to kill himself, "if I happen to become demented." He encouraged his audience "to visit any ward that houses demented people to see how horrible a situation that is for the individuals in spite of the best possible care." We were appalled that, prefaced by the effusive praise of a sitting member of Parliament, a doctor would testify in such a blunt and brutal manner. It's disgusting that the solution proposed by Smith is not to improve the conditions of people living in these wards, but rather to make sure it's legal to euthanize them... Imagine what it would be like to go to the hospital due to illness and hear medical staff question whether or not extreme measures to keep you alive were "worth it." Would that make you feel like a valued member of society, or an inconvenient burden? It's not a fictional scenario - we have experienced this, even before the government made it legal for us to die at the hands of a physician. (The Spectator, Opinion, May 2016)

Court Rulings, Laws and Policies

18% of the *Protection* villain cast were framed as impersonal laws and policies. This mostly referenced the court ruling and replacement law framed as harmfully legalizing MAID, with low-frequency villainization of other policies (e.g. a proposed policy to list death by MAID as death by natural causes on a death certificate, which *Protectors* framed as deceptive).

> Bill C-14 is fatally flawed. Terms are vague, misleading and euphemistic. Palliative care is undermined. Safeguards are limited and have massive gaps and loopholes. And the law legalizes, and thus normalizes, the idea that suicide is a public good when the ill and disabled are the ones dying. Our society can do better than this. (The Spectator, Opinion, May 2016)

Country or Political Representative of Country

11% of *Protection*-framed villains were at the level of country or political representative of a country. This included: Foreign jurisdictions past and present for practices perceived as abusive or overly permissive; the Canadian government for 'stepping backwards and promoting killing as a solution;' and specific politicians framed as appointing activist courts or failing to correct their errors.

> One of Saba's main arguments is that as long as there are woeful gaps in palliative care in the outlying regions of Quebec - and as long as the province's health system is underfunded - the government should not rush ahead with medical assistance in dying. "We have failed to provide the best medical care to all our patients, including palliative care," Saba said… "The government is trying to convince people that being euthanized is dying with dignity when people at the end of their lives should be receiving palliative care, and not just pain control but all the support they need." (Montreal Gazette, News, Oct 2016)

Background Situation or State of Affairs

9% of *Protection*-framed villains framed a background situation or state of affairs as mechanistically contributing to negative outcomes. These included: Widespread avoidance of death planning; inequities in access to palliative care; culture-specific beliefs/values that increase fear of dependence or disability; 'human nature' framed as willing to use the suicide of another for selfish gain; systematic pressure to reduce healthcare costs; a medical training system that fails to prepare physicians to care well at the end of life; "widespread indifference to the rule of law" framed as allowing a court to break its own precedent and effectively invent law rather than interpret it; and an "ultra-liberal ideology" framed as divisively preventing many from affiliating with the Liberal Party.

> Most participants had no end-of-life care plans. Dr. Susan MacDonald, president-elect of the Canadian Society of Palliative Care Physicians, attributed it to people's "inborn discomfort with death.".. Audience participants heard that while palliative care services are generally well run in big cities, the situation "falls apart" outside urban centres. Francescutti said it's a "national embarrassment" that veterinary schools provide more training in pain management than medical schools. (The Vancouver Sun, News, June 2014)

Healthcare Practitioners who Perform MAID

7% of *Protection Camp* villains were healthcare practitioners who perform MAID. When referenced as a hypothetical category, these were subject to more villainizing language, e.g. called "anti-life providers" with "murderous intention" or "[offering] no hope, only a pill or needle to end your life altogether." When vilifying real MAID performers, this typically involved describing specific euthanasia events as particularly villainous for circumstance-specific reasons (e.g. Belgian euthanasia for fear of future disability, or covert MAID in a Jewish care home with policies against the practice).

> A faith-based nursing home has filed a complaint against a medical assistance-in-dying doctor, accusing her of "sneaking in and killing someone" at the Orthodox Jewish home against the centre's policy… the Louis Brier Nursing Home in Vancouver is accusing Wiebe of "borderline unethical" behaviour and has officially complained to the College of Physicians and Surgeons after it learned Wiebe had assisted Hyman's death after-hours without consulting the home. "It was hidden," said CEO David Keselman. "There's no documentation. She came in and I don't know who you are. You can tell me you're a physician, you could tell me you're an astronaut, how do I know? "Imagine the implications for our staff and our residents and their families," he said. "We have a lot of Holocaust survivors. To have a doctor sneak in and kill someone

> without telling anyone. They're going to feel like they're at risk when you learn someone was sneaking in and killing someone." Keselman said the nursing staff had to deal with the "traumatic" news from a Hyman family member that the man they had seen 10 minutes before was dead. "That was tough on our staff," said Keselman. "This isn't an acute-care facility." (The Province, News, Jan 2018)

Ignorance and Naivete

7% of *Protection*-framed villains were ignorance or naivete itself. These were framed as ranging from ignorance about how well-managed end-of-life can be, to ignorance of the difference between end-of-life choices, to the ignorance of thinking publicly funded institutions don't also depend on private funding, and the naivete of thinking MAID won't have "collateral consequences."

> What we don't seem to realize are the terrible ramifications that this law will have on our society as a whole - and the way we treat the most vulnerable among us. In my 20 years of comforting the ill, I have learned that when a patient says something as severe as "I want to die," they don't always mean it literally: It just rips them apart knowing that they have become a burden to their family and society… take a look at how our criminal justice system is formulated. There are laws in place that are designed to protect the innocent, yet it is these very same laws that allow criminals to go free… When implementing laws for an entire society, the main concern is protecting the innocent… The same compelling reasoning should be applied to doctor-assisted suicide. Indeed, there will be specific cases of patients really wishing to die. But allowing them to choose death has collateral consequences: the debasing of the sanctity of life for the majority. (Montreal Gazette, Opinion, June 2016)

System-Level Healthcare Organizations

5% of the *Protection*-framed villain cast were healthcare organizations framed as: systematically failing to provide reasonable alternatives to MAID, potentially pressuring patients towards MAID (including by pressuring health workers to reduce costs of care), recommending deceptive practices, or otherwise applying MAID law in a "dangerous" way.

> Saba, the emergency-room doctor who is challenging assisted dying in court, said that hospitals across Quebec have applied the law in a "haphazard and dangerous" fashion, suggesting doctors routinely err in their patients' prognoses. (Montreal Gazette, News, Oct 2016)

Activists who Push for MAID Legalization or Safeguard Minimization

5% of *Protection Camp* villains were framed to be activists who lobby and push to legalize and expand MAID, or to minimize safeguards.

> When C-14 became law in June 2016, there were already critics of it that claimed it was too restrictive, so you can be sure there are groups that are lobbying to change that law that A. Holierhoek puts his faith in. (The Chilliwack Progress, Letter, March 2018)

Miscellaneous (Abstract) People; "Those who…"

5% of *Protection* villains were framed as profession unspecified people in general ("those …") who might disrespect precautionary safeguards, promote violations of conscientious objection rights, or forbid disabled persons or historians from speaking about euthanasia's history.

> The Nazi Aktion T4 euthanasia program is part of my history as a disabled person. Importantly, it's also part of Schipper's history as a physician. Those who would forbid us to speak of this history, or police our speech as strident and unwelcome, can only fuel doubt about whether its lessons have been learned. (The Times – Transcript, Opinion, June 2017)

Courts or Judges involved in Legalizing Euthanasia

5% of *Protection Camp* villains were the courts (or court members) framed as stepping outside their rightful scope, trying to imitate other countries, make bad law from a hard case, or otherwise leading a "moral and ethical down spiral" by sanctioning killing.

> On significant social policy issues -- such as giving criminal immunity to someone to intentionally cause the death of another, also known as "homicide" -- the appropriate law-making authority is Parliament, not the court. Consistent with other courts around the world, the Canadian Supreme Court in Carter acknowledged the law-making authority of Parliament on this controversial subject. Unlike these other courts, however, the court found the prohibition on assisted death unconstitutional and created no end of mischief in doing so, proving the old legal maxim that "hard cases make bad law." (Winnipeg Free Press, Opinion, June 2016)

Religiously Affiliated Who Fail to Fight MAID

3% of *Protection Camp* villains (sometimes self-referential in a 'would-be' sense) were the religiously affiliated framed as irresponsible if they *fail* to share their values with others, or who fail to fight against MAID hard enough by pressuring politicians to preserve life-affirming laws.

> As we wade deeper into the turbulent waters of physician-assisted death, the issue of any religion imposing its values on Canada becomes more contentious. Personally, I agonize over this. Yet

> how can one remain silent on this critical matter? There are universal values shared by most religions that would be irresponsible not to share. (The Ottawa Citizen, Opinion, May 2016)

Miscellaneous (Specific) People or Groups

3% of *Protection Camp* villains did not clearly fall into any of the above subcategories; I have grouped them here as miscellaneous but specific. These included: a 43-member panel framed as failing to defend an ostracized colleague; a girlfriend who pressured her boyfriend to stay in his car and die by exhaust fumes, and the "privileged and able-bodied" who deprioritize safeguards for the vulnerable.

> Smith made his biases and ableism clear… what we saw and heard at the committee was that safeguards and palliative medicine for people like us are secondary concerns to the desires of privileged and able-bodied men afraid of their own demise to just "check out" where and when they want. (The Spectator, Opinion, May 2016)

Heroes (According to *Protection Camp* Policy Narratives)

17% of the *Protection* story cast (appearing in 30 media articles) were hero characters. In descending order of frequency, heroes as cast by the *Protection* narrative included:

Public, Society, or People in General

26% of *Protection Camp* heroes (across 10 media articles) were the social public whose beliefs, dispositions, or actions are consistent with *Protection Camp* story morals. These were usually referenced by language such as: "community"; "people"; "many people"; groupings of the public (e.g. public attending a consultation); or use of the collective "we" implicitly referencing community.

> Prior to assisted-death laws, including the one already in effect in Quebec, when individuals were diagnosed with a terminal illness, there was only one path: the fight for quality of life and managed care. Patients were surrounded with a supportive family, community and government services, because there was only one option: life. (Montreal Gazette, Opinion, June 2016)

Compassionate Physicians

18% of *Protection Camp* heroes were health workers (real or imagined) framed as 'too compassionate to kill,' who instead help people cope with diminished autonomy, manage symptoms, and otherwise overcome suffering to move on without MAID. *Protectors* also heroized a Quebecois doctor who legally appealed to restore the ban against suicide assistance.

> Regardless of disability, life should be valued… we must make every effort to use the research provided to us to give attentive care and to relieve physical and emotional suffering in a moral way. Some day, it might be you who is suffering and in need of help. What would you want a doctor to do - to help you overcome your suffering and move on? Or would you rather that doctor offer you no hope, only a pill or needle to end your life altogether? (Chronicle-Herald, Letter, Dec 2014)

Country or Country Representatives

15% of *Protection Camp* heroes were Canada or political representatives framed as heroic for: *past* progress made recognizing the value of disabled persons; historical promotion of caring, saving, treating – and not killing; and having 'at least' set a limit on the degree to which MAID was legalized. *Protectors* promised to consider Canada a heroic country again *if* she returns to being a "welcoming, inclusive" country that recognizes dignity as non-losable, and *if* she increases palliative care.

> As a provider of services for people with developmental disabilities, we work to promote full citizenship of people with exceptional needs… In the past 50 years, Canadian society has made tremendous progress in recognizing the value of all people by building communities which include all people… The cautions in the [Supreme Court] decision must be respected. Our concern is that they will not. (Waterloo Region Record, Press Release, Feb 2015)

Religiously Affiliated

13% of *Protection Camp* heroes were the religiously affiliated who caregive for religious motives that simultaneously prohibit killing, who are responsible enough to share their values with others, and who stay true to their faith rather than conforming to a "culture of death."

> For centuries, faith-based organizations and communities have cared for the most vulnerable in our country. We know what it is to journey with those who are facing great suffering in mind and body, and we are committed to serving them with a compassionate love that is rooted in faith and expressed through the best medical care available. We were brought together by a common mission: to respect the sanctity of human life, which is a gift of God; to protect the vulnerable; and to promote the ability of individuals and institutions to provide health care without being forced to compromise their moral convictions. It is because of this mission that we cannot support or condone assisted suicide or euthanasia. (The Ottawa Citizen, Press Release, Feb 2016)

Disability Advocates

10% of *Protection Camp* heroes were disability advocates (sometimes with a disability themselves, sometimes not) who advocate against euthanasia, including a woman with disability who (as co-intervenor) achieved an injunction against Quebec's early MAID bill.

> Pieter Harsevoort and James Schutten live in Hamilton. They testified on Bill C-14 at the House of Commons Standing Committee for Justice and Human Rights. Both are courageous, dignified and well-spoken men, who happen to get around in a wheelchair. (The Spectator, Opinion, May 2016)

System-Level Healthcare Organizations

8% of *Protection Camp* heroes were system-level healthcare organizations, mainly heroizing good-quality palliative care (either already-available or advocated-for).

> Dr. Louis Hugo Francescutti said much can be learned from the exemplary care being given at the West Island Palliative Care Residence where his mother, 82, died peacefully this summer "with a smile on her face."… Rather than look for quickfix solutions in euthanasia or medically-assisted dying, Francescutti said, policymakers should listen to the people who deal with dying people daily. … Francescutti: The stress that my family went through when my mother was in an acute-care environment, and it did not meet her needs as a dying individual ... the moment she was transferred to the West Island palliative centre, immediately you could sense that something was lifted off our shoulders. It was as if, literally, she went to a place that we could not believe existed, at least in Canada. The level of compassion of the staff was in a league of its own. They looked after her and after the needs of the family so well that it was a pleasant experience. It's a great example of what can be done when people do the right thing. (The Gazette, News, Nov 2013)

Family and Friends who Support Life, Not Suicide

5% of *Protection* heroes were family and friends framed as supporting a loved one through caregiving, or speaking up after a loved one's suicide to try to prevent future suicides.

> Batters, a lawyer who worked as the chief of staff to Saskatchewan's minister of justice from 2007 to 2012, said it can be challenging to speak about her family's story but it also gives her strength. "It really helps me to know that I might be helping somebody by something I'm saying and if I can prevent somebody else from being in the situation I'm in, basically an unwilling family survivor of suicide," Batters said. (Chronicle - Herald, News, Feb 2016)

Law Prohibiting Assistance of Suicide

5% of the *Protection Camp* hero cast was a law that prohibits suicide assistance, seen as protecting vulnerable people by the message it sends.

> "An absolute prohibition sends the message that all lives are valued, and worthy of protection from those who may subtly encourage vulnerable people to terminate their lives." (The Globe and Mail, News, Feb 2015)

Moral of the Story (According to *Protection Camp* Policy Narratives)

Protection Camp story morals (that is, propositions from the *Protection* narrative perspective about "what should happen") occurred in 96 documents (32% of documents). According to *Protection Camp* narratives, in descending order of frequency:

	Something should be done about…	Pg.
24%	Baseline Legal Activity	103
21%	Patient Experience	105
12%	Access Categories	106
11%	Conscientious Objection Rights	106
8%	Discourse	107
5%	Healthcare System	108
5%	Morals or Culture	108
3%	Political Activity	109
2%	Time	109
2%	Oversight	110
2%	Health Workers	110
2%	Safeguards	111
1%	Other Rights	111
1%	Religion	111
1%	Deference due Courts v. Government	112
1%	Deference due *Elected* Officials	112

Baseline Legal activity

24% of *Protection Camp* story morals argued that something should be done about baseline legal activity. Only 59.5% of these baseline-legality story morals explicitly advocated for criminalization of suicide assistance or active + direct euthanasia. The remaining 40.5% were surprisingly roundabout in phrasing, at least as compared to *Freedom Camp* story morals about baseline legality. *Protectors* seemed sometimes shy to say they wanted any act categorized as criminal, although it seemed implicit that this was what they wanted.

21 articles (pre-decriminalization) explicitly argued that suicide assistance should remain a criminalized act. Four articles (post-decriminalization) explicitly argued that the assistance of suicide should be re-criminalized. Four articles argued (with an implicit tilt towards the *Protection* position) that thoughtful laws deserve careful consideration before implementation. Three articles proposed preparing to acknowledge that MAID legalization was a mistake, and to amend the laws again if future evidence indicates. Three articles encouraged the reader to consider risks of legalization to the vulnerable (implicitly proposing that MAID ought not be legalized). Two articles encouraged readers to perceive inconsistency in the law legalizing MAID (seemingly implying, in context, that an inconsistent law should not be introduced). Two articles proposed regulations for MAID legislation. One article argued that euthanasia should be kept criminal in law, but not prosecuted in practice. One article argued that laws should be structured to prevent collateral consequences. Finally, one *Protector* phrased his position as (underlined emphasis mine): "I don't think it's necessarily the way society should go, to say that certain people can be killed by other people… who are sanctioned by the state… We've had the ability to de-animate human beings forever and we've had the ability to do that through chemicals for hundreds of years, and yet societies have not said that's the thing to do." Such linguistic reluctance to advocate for a specific law in an unqualified, straightforward way struck me as noteworthy, particularly compared to the less bashful legal advocacy of *Freedom Camp* narratives.

> The Council of Canadians with Disabilities, which has intervened in several court cases, says many patients seek assisted suicide not because of pain, which can be managed, but because of fears of losing independence and becoming disabled. Such motivation, they argue, is insufficient reason to legalize assisted suicide and represents a threat to the disabled and vulnerable members of society. (Prince George Citizen, Editorial, Sept 2013)

Experience of Prospective MAID Recipients; Response to Suffering

21% of *Protection*-framed story morals argued that something should be done about suffering, or about the experience of prospective MAID recipients (aside from simply performing or withholding MAID). 17 articles argued to enhance experience by making sure vulnerable people are effectively protected by legal safeguards and healthcare practice from abuse, duress, or pressure to choose suicide. Nine articles argued to improve experiences by increasing access to and quality of Canadian palliative care, so that people feel they have real options. Nine articles argued to improve experiences by addressing psychosocial issues or existential distress with comfort, inclusion, and bolstered meaning. Four articles argued that more resources must be provided to help people (especially those with disabilities) thrive. Three articles argued to improve experiences of persons with mental illness by helping them find effective treatment to live well rather than die. Three articles argued broadly that what people need to experience is love as contrasted with killing: help overcoming suffering, instead of discouraging agreement that some suffering cannot be overcome. Two articles argued to eliminate 'Death before Disability' narratives to reduce hopelessness and disrespect of disabled persons. And one article broadly argued to address suffering by killing the pain, not the patient.

> Physician assisted dying is not a real 'choice' for those with mental illness if we don't first offer them adequate care and support. And the unfortunate reality is that, in Canada, mental health is vastly under serviced… vulnerable people may come to desire death due to a lack of any reasonable alternative to their suffering. For this reason, many have called for us to redouble our attention to providing access to high quality palliative care so that people are not driven toward medically assisted death by uncontrolled pain. With the committee inclusion of psychological suffering due to mental illness as a condition eligible for physician assisted dying, we must ask the same question about access to high quality mental health care and social support. How can we offer one as a 'choice' without the other? … An article published earlier this month in JAMA Psychiatry reviewed 66 cases of medical aid in dying provided to people with psychiatric illnesses in the Netherlands between 2011 and 2014. The review found that most of these cases were women (70 per cent) with chronic severe conditions, and 56 per cent were described as socially isolated or lonely. As Dr. Paul Appelbaum commented in an editorial accompanying the article, these results raise "the concern that physician-assisted death served as a substitute for effective psychosocial intervention and support." … Attention to mental health care and social supports must begin well before a person reaches this point. (The Times – Transcript, Opinion, Mar 2016)

Limit MAID Access Categories

12% of *Protection* story morals for MAID access categories to be limited. Eleven articles proposed: No MAID for the mentally ill; Five proposed: No MAID for minors. Four argued more generally for strict access limits (e.g. "hopeless cases"). Three argued to keep Bill C-14's criterion that death already be "reasonably foreseeable". One article argued against advance directives. One article argued that legislation should include additional restrictions to protect the newly disabled while they adjust to their new reality. And finally, one article argued against permitting simultaneous MAID for romantic partners, lest one partner be unduly influenced by the other's choice.

> An overwhelming majority of Canadians believes psychological suffering on its own should never be grounds for granting a doctor-assisted death… The results suggest Canadians are not in line with recommendations in a parliamentary report calling for broad access to assisted death. The Liberal-dominated panel's report, released in February, called for extending assisted death to the mentally ill. But 78 per cent of those surveyed said "psychological suffering" on its own should not meet criteria for a doctor- hastened death. The opposition was even sharper among those 55 and older. (The Province, News, Apr 2016)

Conscientious Objection Rights

11% of *Protection* story morals advocated for conscientious objection rights, whether the right for an individual to object (the majority of narratives) or for an institution to object. 13 articles argued for protection of individual health workers when conscientiously objecting both to performing and referring for MAID. (Conscientiously objecting doctors recurringly framed referral as 'complicity in the killing of a patient' and therefore something they cannot agree to.) Eight articles argued for conscientious objection rights in general (not specifying a distinction between performance/referral). Four articles argued that institutions should have the right to prohibit on-site MAID; one article argued these should lose no public funding. Finally, one article proposed that a national oversight committee should take charge of protecting these rights.

> It is clear that reasonable people, with or without religious faith, can have a well-founded moral conviction that prevents them from becoming engaged in any way in the provision of assisted suicide and euthanasia. It is essential that the government ensure that effective conscience protection is given to health care providers. They should not be forced to perform actions that

> go against their conscience, or to refer the action to others, since that is the moral equivalent of participating in the act itself. It is not right to say: you do not have to do what is against your conscience, but you must make sure it happens. (The Ottawa Citizen, Press Release, Feb 2016)

Discourse (Words and Conversation)

8% of *Protection Camp* story morals argued that something should be done about discourse: the form, content, interpretation or frequency of speech. Five articles encouraged people to talk about dangers of MAID (especially referencing historical and foreign precedent). Three articles argued that words are 'getting in the way,' and society owe it to the vulnerable to improve at listening to hearts instead of mere words. Three articles proposed public messaging from the palliative care community, to raise awareness about existing good care and the 'true need' (expanding access to this good care). Two articles proposed replacing "death before disability" narratives with "welcoming and inclusive" narratives. Two articles proposed more input from religious persons into the conversation. Two articles framed talk itself as dangerous (when the MAID debate 'distracts, and saps energy' from other efforts; or if a doctor suggests MAID which could shake "trust and confidence" in healthcare). Finally, one article argued that a parliamentary committee should carefully consider the conversation points raised by *Protectors*, especially about foreign abuse and protecting the vulnerable and care worker rights.

> Nothing about medically-assisted death is ahistorical. As we review current law and practice, and consider potential expansion to the Criminal Code exemptions that now permit Canadian doctors and nurse practitioners to end the lives of certain patients, surely we have the maturity to invite history into the conversation. Doctors, at times, have killed. This is fact. Often, when they have killed or harmed, they have not acted alone but as agents of state authority. With all of their immense skill and influence, doctors have played indispensable roles in residential schools and asylums in Canada, comfort stations in Southeast Asia, enhanced interrogation facilities at Guantanamo Bay and extermination centres in Nazi Germany. People with disabilities have suffered violence and harm at the hands of doctors, parents and caregivers. Sometimes, as with Satoshi Uematsu in Sagamihara, Japan, the world has instantly recoiled in horror. Sometimes, as with parent Robert Latimer in Saskatchewan, a court of law may ultimately uphold conviction, but not before public opinion solidifies in support of the perpetrator. Sometimes, as with Brandt, a nation colludes. (The Times – Transcript, Opinion, June 2017)

Systems Level Healthcare Organizations

5% of *Protection Camp* story morals argued for action about system-level healthcare organizations. Eight articles proposed improving access to palliative care. Two articles specifically argued to build on expertise emergent from palliative care centres of excellence, to reproduce these. One article argued that palliative institutions should consider MAID outside their scope of care. And one article argued that more help should be provided (implicitly through the healthcare system) to "the mentally ill or anyone who is so emotionally distraught they feel the only way out is to take their own life."

> Many will require <u>hospice and palliative care, to effectively address pain and other symptoms</u> that are common in people with life-limiting illnesses. They <u>should be able to get these services not just in hospitals and residential hospices but also in their communities and in long-term care facilities</u>… In Oregon, the government made a clear commitment to providing <u>universal access to hospice and palliative care</u> as well as physician-assisted death. So when the Trudeau government introduces legislation to regulate physician assisted-death, it should also take steps to <u>ensure</u> that Canadians will have <u>adequate access to end-of-life care</u>. It should <u>develop and fund a national strategy to ensure that hospice-level palliative care is available</u> throughout Canada and in all settings where people nearing the end of their lives may be getting care. (Toronto Star, Opinion, Apr 2016)

Morals and Culture; Values and Ideas

5% of *Protection Camp* story morals argued that something should be done about morals or culture: values or ideas. Four articles argued broadly that society should collectively affirm the values of "life and the sanctity of human life." Two articles argued to examine and reject the MAID-underlying idea of "individual liberty no matter the social cost", proposing instead cultural limits on individual liberty in order to protect the vulnerable. One article argued that the "shift from kill the pain to kill the patient" is the wrong cultural direction to move in. One article argued that we should protect certain cultural values (e.g. "the passion to save, the inexhaustible energy to treat") from the impact of legalized euthanasia , to avoid "slipping" into a culturally "more resigned approach to life's challenges, leading to many missed fulfilments and true achievements". Finally, one article framed the cultural choice as *between* "love" and "death."

> In an article published in the Ottawa Citizen in October, Frazee said state-sanctioned assisted death raises questions over how far personal freedoms should extend. "At the heart of this debate, we must choose between competing visions of our social fabric. Shall we uncritically submit to the voracious demands of individual liberty no matter what the social cost?" she wrote. "Or shall we agree that there are limits to individual freedom, limits that serve us all when we are vulnerable and in decline." (Star – Phoenix, News, July 2015)

Political Activity

3% of *Protection Camp* story morals argued that something should be done about political activity. Two articles argued that parliament should carefully design/enact safeguards/oversight to prevent abuse. One article argued that the Liberal caucus should permit its MPs to vote according to conscience rather than along party lines. One article argued that parliamentary leaders should have used the "Not-withstanding Clause in the Charter of Rights" to overrule the Supreme Court's decriminalization decision. And one article argued that MAID opponents should be trusted on political consultation panels about MAID, to help develop the process for implementation.

> The Grits should reconsider asking MPs to toe the party line on an issue of this nature, Batters said. "I urge the Liberal caucus to think twice about that and give their members of Parliament the opportunity to vote with their conscience," she said. (Chronicle – Herald, News, Feb 2016)

Time

2% of *Protection Camp* story morals argued that something should slow down. Three articles argued that MAID should stay impermissible until at least after Canadians first have access to adequate palliative care. One article made the general argument that thoughtful laws take time to be crafted, and that Canadians/politicians should stay open-minded to future evidence prompting reversal.

> But Saba also invoked a novel argument - that as long as access to palliative care in Quebec remains inadequate, the dying with dignity law should not be enforced. (Montreal Gazette, News, Dec 2015)

Oversight

2% of *Protection Camp* story morals made proposals about oversight. Two articles argued that “stringent safeguards and oversights” (non-specified) must be enacted by parliament to prevent abuse; one article argued for recording MAID on death certificates as part of oversight and transparency.

> Doctors' leaders in Quebec are poised to recommend euthanasia be kept off death certificates. Instead, doctors could be encouraged to classify deaths by lethal injection as "natural" deaths on public death records… Euthanasia opponents are denouncing the proposal as an attempt to conceal the truth... An assisted death is not a "natural" death by definition, said Dr. William Cunningham, a Victoria emergency and family physician and past president of Doctors of BC… "there has to be some way of monitoring what is going on" in every jurisdiction in the country. The only consistent document, he said, is the death certificate. The Canadian Medical Association said it is seeking "clarity" on the issue. "I think there are members of the profession who say, 'let's make sure we're as accurate and as honest as we can be in our reporting and, if it is assisted dying, let's say that,'" said Dr. Jeff Blackmer, the CMA's vice-president of medical professionalism… Some doctors say a coroner or medical examiner should investigate every assisted death. (The Windsor Star, News, Sept 2015)

Frontline Healthcare Practitioners

Only 2% of *Protection Camp* story morals argued that something should be done about frontline healthcare practitioners (apart from protecting their right to conscientious objection). One article proposed that doctors *should* object, without proposing a legal status that should pertain to this objection. One article argued that in between decriminalization and parliament’s replacement law, a pharmacist should “obtain legal advice” before filling a prescription for a lethal dose. And one narrator argued that with euthanasia now legal, health care providers should be “required to wear clothing that makes their stance on assisted death immediately obvious” (suggesting blue versus green scrubs) so she can make an informed choice about the providers from whom she is comfortable receiving care.

> "Physician-assisted suicide is not a suicide as far as I'm concerned. This is a killing. I'm certainly not interested as a physician," said one doctor, who took care of his wife when she was dying 30 years ago. "If physician-assisted suicide becomes legal in Canada we should have nothing to do with it," another doctor said. In cases of patients with dementia, the ethics would be "horrific," he said. "They didn't consent to that." (The Gazette, News, Aug 2013)

Safeguards

2% of *Protection Camp* story morals argued that safeguards should be increased or maintained. Perhaps interpreting discussion of safeguards as 'giving up' and 'collaborating' on MAID, *Protector* discussion of safeguards short of absolute prohibition (the typical 'minimum safeguard' advocated: see Baseline Legality) were relatively rare. Only three *Protection Camp* articles advocated safeguards after MAID legalization, and these were non-specific: proposing respect for "cautions" in the bill regulating MAID, and generally proposing "safeguards and oversight" to prevent abuse.

> The court ruled that permission for physician-assisted death must be strictly limited to a competent adult, clearly consenting to the termination of life where the person has a grievous and irremediable medical condition causing enduring suffering that is intolerable to the individual… We must ensure that abuse and disproportionate impact on vulnerable people does not materialize. The cautions in the decision must be respected. Our concern is that they will not. (The Spectator, Press Release, Feb 2015)

Other Rights

1% of *Protection* story morals (two articles) advocated "rights" beyond conscientious objection. These argued that Canada should establish a legal 'right to palliative care' (or a right to resources), and advocated the "right" to worry-free health care and life in a society with certain 'universal' values.

> The implications on the psyche of physicians are enormous. With termination as part of the new medical vocabulary, medical practitioners will have their determination compromised. Naturally, patients will wonder whether their doctors are fully dedicated to their survival. By acceding to the rights of some, we are almost unavoidably removing the right of the overwhelming majority of Canadians to worry-free health care, free from the anxiety about how committed their health-care providers are to their desire to live… Reverence for life and awe of its sanctity have defined us. The passion to save, the inexhaustible energy to treat, the infinite capacity to care to the last natural breath - these are universal values, Canadian values, which are religiously imbued but also stand on their own. These are values the right to which we deny to our peril. (The Ottawa Citizen, Opinion, May 2016)

Religion

1% of *Protection Camp* story morals (two articles) argued that something should be done about religion. These argued that Muslims and Catholics should keep well-informed of their ethical and religious obligations, especially elaborating upon Catholic obligations to avoid advocacy for, or participation in, human-killing, and to resist temptation to imitate culture, living instead by faith.

> The hot button topic of physician assisted-dying has some religious leaders speaking out, offering faith as a form of guidance… Both [Halifax Muslim Leader Jamal] Badawi and [Halifax-Yarmouth] Archbishop Anthony Mancini encourage <u>followers</u> of their faith to <u>remain well informed on what is at stake</u> in legalization of medically assisted suicide. (Chronicle – Herald, News, June 2016)

Deference due to Courts of Law versus Government

One *Protection Camp* story moral argued that courts should be overridden by government representatives who themselves defer to the public, in this case by invoking the legal mechanism of the "Not-withstanding Clause" to overrule the Supreme Court.

> A number of normal people, recognizing that this disgusting declaration could be a danger to everybody in the country, spoke out. They said, "The <u>Not-withstanding Clause in the Charter of Rights must be used</u> to <u>stop this dictatorial and obscene decision</u>." Unfortunately, the leader of the land at that time did not appear to have the courage to use this safeguard… (Chilliwack Times, Letter, Mar 2016)

Deference Due to Elected Officials

Finally, one *Protection* story moral argued (via citing court perspective) that elected officials (vs. unelected officials or courts) should craft the specifics of law in Canada, and are to receive deference.

> The Supreme Court stated in the Carter case that "complex regulatory regimes are better created by Parliament than by the courts." The creation of such a regime is now in the <u>democratically elected</u> hands of Parliament and <u>deference is owed</u>. (Winnipeg Free Press, Opinion, June 2016)

Narrative Strategy (In *Protection Camp* Policy Narratives)

The *Protection Camp* recurringly employed four main narrative strategies: Framing euthanasia legalization as a "slippery slope"; employing a narrative tone of anxious concern; resisting *Freedom Camp* word definitions; and emphasizing distinctions between practices.

Slippery Slope

Protection Camp narratives strategically framed baseline legalization of suicide assistance as part of a slippery slope, emphasized ways that 'slippery slope' arguments can be valid and sound,[19] and presented foreign case studies as evidence of euthanasia slope-slippage in euthanasia-legal countries.

> Mr. Mortier is now a passionate opponent of Belgium's euthanasia law, which has been gradually broadened since it was introduced in 2002. He has a warning for Canadians: Beware the slippery slope. What happened to his mother "has nothing to do with humanism… This has nothing to do with taking care of a human being." … When those countries introduced right-to-die laws, everybody had a clear idea what they meant – or thought they did. The laws were meant for cases of unbearable suffering from incurable illnesses, such as terminal cancer. Euthanasia would be permitted only under tightly controlled circumstances, with careful oversight and close consultation with the patient and family doctor over a long period of time. It hasn't quite worked out that way. Physicians are now killing people they have barely met. Some of these people have psychological and psychiatric disorders, such as anorexia or depression. In 2012, 42 people with dementia and 13 people with psychiatric problems were medically killed in the Netherlands. A service launched by a right-to-die group has 30 mobile teams that make house calls to people who want to die but whose family doctors may be unwilling to participate. One of the people its staff put to death was a 63-year-old man who had no friends or family and couldn't face the prospect of retirement. Another was a 54-year-old woman with a pathological fear of germs… Clinic director Steven Pleiter told the Daily Beast that offering psychiatric patients the option of assisted suicide is important. The group also believes that assisted death should be available to anybody over 70. Even Boudewijn Chabot, a pioneer of the Dutch euthanasia movement, thinks things have gone too far. "The legislation is off the rails," he told a Dutch TV program last month. Last week, Belgium passed a law extending the right to die to children who meet the criteria and request it. (The Globe and Mail, Opinion, Feb 2014)

Tone of Concern, Anxiety

Protection narratives typically adopted a narrative tone of anxious concern, for vulnerable people and for health workers facing pressure towards actions with which they are uncomfortable.

> The ruling is creating deep discomfort in a field of medicine where "cures" are rare and where many worry there is every possibility severe depression and other mental illnesses could meet the test for assisted suicide or even euthanasia…. "I have been approached by many psychiatrists who have serious concerns about physician-assisted death being applied to mental illnesses," said Dr. Padriac Carr, president of the Canadian Psychiatric Association… "For weeks or months, a patient could be suicidal and yet that situation could change. "The big fear for

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[19] For example due to reduced 'costs' and opposition to each next step of a sequence already begun. Alternately, when a 'first premise' is framed such that it equally leads to multiple conclusions, instead of stopping at only one conclusion.

> psychiatrists is that they may be participating in physician-assisted death when there is a chance for treatment." (The Province, News, Sep 2015)

Defining Terms

Whereas *Freedom* advocates adhered to one set of definitions (for words like 'dignity', 'liberty', 'medicine', 'harm', 'neglect', or 'compassion', *Protectors* resisted these increasingly popular definitions, instead persisting in defining these terms according to their own narrative framework. In *Protection* narratives these words or concepts were typically defined in the following ways:

***Dignity* as Non-Losable, or *'Self-Dignity'* as Lost if Feel Social Pressure to Euthanasia**

> Our society can do better than this. What if, instead of the "right" to doctor-assisted death, we were given the right to palliative care, or the resources to help us remain productive members of society? What if, instead of assuming that dignity can be lost through disability or disease, that we saw all people - including those with a disease or disability - as inherently dignified simply because of who they are? That is the welcoming, inclusive Canada we want to live in. (The Spectator, Opinion, May 2016)

***Autonomy* as an Illusion; True Freedom as Protection to Live Supported Lives**

> Logically, better palliative care ought to make assisted suicide obsolete. Not so, said Wiebe. About 90 per cent of the people who get an assisted death in other jurisdictions, she admitted, are not doing it for reasons that palliative care physicians can help with. They are not doing it because of pain, they are not doing it because of vomiting, they are doing it because of loss of autonomy. And that, said Wiebe, is the major reason that people choose to have an assisted death… But is it not possible that pure autonomy is an illusion? From the elderly patient who walks into my pharmacy to the young man with multiple sclerosis who drives in on his scooter to sick children held in their mothers' arms, we all have limitations. And if the sick have lost some autonomy, rarely are the healthy self-sufficient. My life would fall to pieces without electric power, meaning no computer or iPhone. What would I do without my car? My life would certainly be drab without my family and friends. My work life would be a mess without my colleagues… And so, Dr. Wiebe, the moment a patient invests you with the power to take his life, free of prosecution, the moment the IV drugs are pumped into his veins, at that moment that man, that woman or that child loses all autonomy, he may gasp - he may have a change of heart - but it will be too late. So how did we ever shift from kill the pain to kill the patient? The answer is an illusion. (The Province, Opinion, Mar 2016)

***Medicine* (and implicitly, *Harm* or *Neglect*)**

Protection Camp narratives typically defined medicine as ordered towards improving the health or comfort of a living body (in contrast to 'medicine' describing a skillset applicable to different ends). *Protection* narratives typically framed medicine along Hippocratic lines, and as only trustworthy when exclusively devoted to protecting life. Implicitly, *Protection* narratives defined harm or neglect as occurring when medical practitioners fail to conduct themselves in a life-affirming way.

> "The classic words of the Hippocratic Oath bind medical practitioners to keep patients 'from harm and injustice' and not to 'give a deadly drug to anybody who asked for it' nor to 'make a suggestion to this effect,' " Archbishop Paul-Andre Durocher of Gatineau writes in a letter to departing justice minister Peter MacKay. "The court's ruling not only erodes society's appreciation for human life," Durocher writes, "but also the trust and confidence all people, particularly those most vulnerable, should have in medical personnel and health-care institutions to protect their lives." (Montreal Gazette, News, June 2015)

Compassion

Protection Camp narratives typically defined compassion along etymologically traditional lines (Latin ‘compati’ or ‘compassio’, meaning “to suffer with”). *Protectors* typically framed compassion as involving ongoing presence and caregiving accompaniment ‘with’ a person who is suffering, framed in contrast to cutting presence short through hastening death.

> Doctors have provided assisted dying since ancient times. But now, the most thoughtful response to a human being dying would be an unending, compassionate presence, not the hastening of someone's death. To feel that one is a burden because they are in pain or suffering is the perpetuation of a lie that one is only a dignified human being if he or she is not ill. We need to take the time and effort to investigate and utilize complementary and alternative therapies that show promise in other countries. We need to invest in training more physicians, therapists and nurses in palliative care and long-term illness care. (Calgary Herald, Letter, Oct 2015)

Emphasizing Distinctions Between Practices

In contrast to the *Freedom Camp*’s narrative strategy of conceptual line-blurring, *Protection Camp* narratives adopted a strategy of conceptual line-drawing, particularly distinguishing between actions intended to directly kill as an end goal, and actions intended to allow natural death to occur.

> Death comes to us all, and so patients are fully justified in refusing burdensome treatment that only prolongs the inevitable process of dying. But there is an absolute difference between dying and being killed. It is our moral conviction that it is never justified for a physician to help take a patient's life, under any circumstances. (The Ottawa Citizen, Press Release, Feb 2016)

Chapter 6: *Fence-Sitting* Camp Policy Narratives

The *Fence-sitting* policy narrative camp avoided advocacy about the baseline legal status of suicide assistance and/or active + direct euthanasia (or, rarely, expressed such an unusual admixture of *Freedom Camp* and *Protection Camp* narrative elements as to seem effectively 'camp-neutral'). I chose to name this camp '*Fence-sitting*' because of the characteristic feature by which a narrative typically became coded as belonging to this camp: That is, 'sitting on the fence' (avoiding *explicit* advocacy) about whether or not MAID should be, at baseline, legal or illegal in Canada. Narratives coded as belonging to the *Fence-sitting* camp were not 'on the fence' about all issues, often advocating with passion for peripheral issues beyond the question of baseline legality (for example, arguing that a level of euthanasia already legalized should not be expanded further). Characteristically reticent to be perceived as aligning with polarized 'extremes' on this issue, *Fence-sitting* narratives often appealed for 'both sides' to be heard, and for a syncretic solution to simultaneously resolve the concerns and respect the rights asserted by both the *Freedom* and *Protection* camps. For example (emphases mine):

> It's not often that an issue comes along where I struggle to figure out where I stand, especially after considering various points of view. But like many people I've spoken with recently, I sure find myself conflicted about euthanasia… We live in a pluralistic democracy… If any issue needs a balanced, careful approach, euthanasia is it… I understand why people want euthanasia, now declared a Charter right by our highest court. I just hope other people's rights will be respected and that the procedure will be limited to hopeless cases. (The Province, Opinion, Mar 2016)

This chapter analyzes the *Fence-sitting* narrative policy position. It examines the setting as described by the *Fence-sitting Camp,* the characters, the moral of the story (i.e. preferred policy), and the most prominent narrative strategies, accompanied by media examples with underlined emphases added. As shorthand, I refer to *Fence-sitting Camp* policy advocates as *Fence-sitters*.

Setting (According to *Fence-sitting Camp* Policy Narratives)

Fence-sitting Camp policy narratives collectively describe the setting of this story as:

1. Complicated by contemporary medical, religious, and social realities;

2. One in which there is public consensus about needing better palliative care (and needing to discuss end-of-life issues with loved ones), but no public consensus about euthanasia;

3. One in which foreign precedent is a fruitful source of data, one way or another.

Details and media examples follow.

1. A Complicated World

Fence-sitters typically described the world as too complicated – in terms of moral, social, and medical-institutional realities – for quick or obvious answers to either 'extreme,' whether a complete ban on euthanasia, or expansive permissiveness of euthanasia. *Fence*-sitters confirmed certain setting details noted in *Freedom* or *Protection* narratives, such as the MAID conversation seeming driven by baby boomers amidst a generational and technological shift.

> With baby boomers facing infirmity and mortality and the medical community's burgeoning abilities to sustain life, questions about the withdrawal of care and the right to die have come to the forefront. The Supreme Court of Canada and B.C.'s top courts are wrestling with cases that raise these concerns, entangled in a thorny thicket of religious beliefs, fundamental rights and health-care policy. (The Vancouver Sun, Opinion, Dec 2012)

2. The Public is United on Palliative Care and Conversation, Divided on Euthanasia

Fence-sitters typically framed the conversational setting as divided over the appropriate legal status of lethal injection, but united about topic- peripheral topics of wanting improved palliative care or needing to talk more with family about end-of-life care plans.

> News reports three months ago said Canadians are divided on whether a ban on medically assisted death should be maintained… It found that while Canadians were split over the contentious issue, there was much desire across the country for more palliative care to ensure a "good death," free from pain and with as much dignity as possible. The association's town hall sessions found there was "universal agreement" about the need to discuss end-of-life care with family, CTV News has reported. But the organization said just 30 per cent of Canadians have had that conversation. (Chronicle – Herald, News, Sept 2014)

3. Foreign Precedent is a Useful Source of Data

Fence-sitters typically described foreign precedent dispassionately, as a useful resource from which to gather data. Rare value-judgments about this data tended to be implicitly critical, e.g. reporting on a foreign clinic reprimanded by its oversight body for over-expansive application of euthanasia.

> The Canadian Medical Association has <u>consulted medical associations in jurisdictions around the world where euthanasia or assisted suicide is legal</u> to devise possible protocols for Canada if the federal law is changed…The CMA has spent the past year consulting medical associations in <u>Oregon, Washington, Montana, Vermont and New Mexico, U.S. jurisdictions</u> where physician-assisted death is legal, to find out "what has <u>worked</u>, what <u>hasn't worked</u> and <u>how Canada can learn from those experiences,</u>" Blackmer said. "We've also had long conversations with the <u>Netherlands, Belgium and Switzerland,</u>" he said. "We're now in the process of internal consultation and thought processing to look at some of the options and possibilities, to try to come up with a reasonable suggested framework and approach." (Star – Phoenix, News, Dec 2014)

Cast of Characters (According to *Fence-Sitting Camp* Policy Narratives)

73 documents (24% of documents) contained *Fence-sitting* characterization: that is, at least one appearance per document of at least one *Fence-sitting* victim, villain, or hero. *Fence-sitting*-framed victims appeared in 43 documents (14.33% of documents); *Fence-sitting*-framed villains appeared in 33 documents (11% of documents); and *Fence-sitting*-framed heroes appeared in 29 documents (9.7% of documents). Of all *Fence-sitting* characters, 41% were victims, 31% were villains, and 28% were heroes.

<u>Victims</u>	Pg.	<u>Villains</u>	Pg.	<u>Heroes</u>	Pg.
57% Patient……………	119	29% Country, Gov't………..	121	39% Country…………	125
26% General Public….	120	15% Discourse……………....	122	36% Health Workers…	125
11% Health Workers…..	120	15% Background Situation…	122	19% General Public….	126
4% Misc. Specific…….	121	9% Health Workers……….	123	6% Family/Friends…	126
2% Healthcare System..	121	9% Activists………………	123		
		6% Ignorance……………..	124		
		6% Court, Judge………….	124		
		6% Misc. Specific………..	124		
		6% Healthcare System……	124		

Victims (According to *Fence-sitting Camp* Policy Narratives)

41% of the *Fence-sitting* story cast (across 43 media articles) were victim characters. In descending order of frequency, victims as cast by the *Freedom* narrative included:

Prospective MAID Recipients

The primary victim of the story as told by the *Fence-sitting Camp* was the prospective MAID recipient, at 57% of *Fence-sitting* victims. Without entering unambiguous *Freedom* or *Protection* territory by proposing a pro-MAID or anti-MAID 'solution,' *Fence-sitters* framed prospective MAID recipients as victims for the same basic reasons as did *Freedom* advocates and *Protectors*. However, while *Freedom* advocates emphasized the victimhood of suffering that would be relieved by death, and *Protectors* emphasized the victimhood of vulnerability to death, *Fence-sitters* typically acknowledged both types of victimhood. Without proposing MAID-specific policies one way or another, *Fence-sitters* subdivided this victim group into: Vulnerable at-risk persons who require protection from abuse when euthanasia is legal (e.g. the mentally ill already systematically abused and neglected by an under-funded mental health system; persons with disabilities; the very old and very young; dementia patients; uncommunicative persons; persons with treatable conditions; persons with unaddressed existential suffering or who fear being a burden; persons already euthanized in foreign locations for inappropriate reasons); anyone suffering to the point of wishing for death; anyone fearing pain, experiencing pain, or dying in pain; anyone who ages in unhealthy condition because of poverty or other social ills; anyone whose MAID goes 'wrong' with death not as gentle as hoped; patients harmed by a "battle narrative;" and (an unusual case) persons who die by suicide in general, especially those not resuscitated in Quebec E.R.s during a period of confusion after MAID law enactment.

> Nowhere else in medicine is the battle rhetoric more entrenched than in cancer. And it's defeating people. Military metaphors can push people into accepting brutal treatments or "maximum tolerated doses" of chemotherapy when there's little hope of extending survival. They keep people from accepting palliative treatment - care that not only eases symptoms but can also prolong life - because it seems too much like surrendering, while driving others to

> demand needlessly aggressive treatments for cancers that would likely never kill them. Framing cancer as a kind of war within our bodies can also seriously harm a person's emotional psyche. "Who wants to go to war with themselves? … How is it ever helpful to think of oneself as a victim who was randomly attacked and now you're trying to kill your assailant in order to survive?" … Studies have shown people who are encouraged to "fight" and "be positive" are more likely to conceal their own emotional distress… Dr. Seema Marwaha is an internal medicine specialist in the Toronto area. Last August, a man dying of pancreatic cancer arrived in her emergency room. He was frail, jaundiced and in serious pain, and he had come seeking one thing: a doctor assisted suicide. "I don't want to be remembered a loser," he told Marwaha. "I don't want my obituary to say that I lost the battle." … if the message conveyed is somehow "that there's a choice to fight or give up" - it's hard to reframe the conversation if things don't go well. Too often, the language used by doctors adds insult to injury: patients "fail" chemotherapy, instead of the drugs failing them. (The Windsor Star, Feature, May 2017)

Public, Society, or People in General

The general public were framed as 26% of victims in *Fence-sitting* narratives. This usually referenced the 70-85% of Canadians said to lack access to palliative care in Canada, leaving Canadians anticipating death under circumstances they dread and lacking "real" alternatives to MAID. *Fence-sitters* less-frequently described society as victimized if/when: safety or trust in doctors shaken by MAID; courts make laws instead of elected representatives; taxpayers lack explanation for actions at a publicly funded university; or rights are disrespected for those who aren't "atheist secular humanists." One article framed people in general as victims simply because we all die someday.

> If the complete law is invalidated, they warn, "all consensual killings and assisted suicides, not just physician-assisted deaths, would no longer be criminal offences." If the court only intended to make an exception for physician-assisted suicide, "uncertainty would still remain as to the precise circumstances in which a physician would be eligible to benefit from the exception." Both situations "pose serious risks to public safety, especially if the provisions are completely struck down." (The Ottawa Citizen, News, Dec 2015)

Frontline Healthcare Practitioners

In 11% of cases, *Fence-sitting Camp* victims were framed as being health workers. These were framed as forced into a nerve-wracking, burdensome "ethical quagmire" of participation in a practice they didn't sign up for, or frustrated by the lack of training around MAID and technical issues such as "excessive paperwork required and the lack of good data collection." Two unique narratives sympathetically framed Quebecois doctors as victims insofar as they were "confused" by MAID legalization to the point of ceasing to resuscitate solo suicide victims in the emergency room. (I coded these as both doctor-victim and as doctor-villain, though such characterization was mild in both cases.)

> The fundamental question of whether MAID is part of the scope of medicine is important for two reasons. First, assisted death provides significant power to physicians. Second, it imposes a significant burden on them, says Trudo Lemmens, the Scholl Chair in health law and policy at the University of Toronto's faculty of law. (The Ottawa Citizen, Opinion, Oct 2016)

Miscellaneous (Specific) in Other Category

4% of the *Fence-sitting* victim cast was one specific sociologist whose university prevented him from continuing his research into new techniques of suicide assistance, prior to MAID's legalization.

> The Canadian Association of University Teachers (CAUT) has formed a high-level committee to investigate claims that Kwantlen University College sociologist Russel Ogden was unjustly denied the chance to research new techniques for assisted suicide. "In the face of it looks as if there has been a violation of academic freedom," … Despite receiving earlier ethics board approval, Ogden has since been told by Kwantlen's administration he cannot "engage in any illegal activity, including attending at an assisted death." (Leader Post, News, July 2008)

System-level Healthcare Organization (Medical Regulatory Authorities)

2% of the *Fence-sitting* victim cast was the physicians' college burdened with developing rules for MAID if the government cannot do so in time.

> The head of the organization that regulates New Brunswick's doctors says it's "practically impossible" for the province to introduce rules to govern doctor-assisted death in advance of a deadline that could see it handed that responsibility. … Schollenberg added he remains unclear of the role of the college in forming doctor-assisted death rules. The sharp assessment is of importance because if no legislation is put in place by the two levels of government, standards or guidance to doctors then falls to medical regulatory authorities. (Telegraph-Journal, News, Sept 2015)

Villains (According to the *Fence-sitting Camp* Policy Narrative)

31% of the *Fence-sitting* story cast (across 33 media articles) were villain characters. In descending order of frequency, villains as cast by the *Fence-sitting* narrative included:

Country, Government, or Politician

29% of the *Fence-sitting* villain cast was framed as timid, lazy, or avoidant politicians insufficiently evidence-based in crafting policy or too slow/silent in completing/clarifying legislation.

> This country's highest court ultimately gave Parliamentarians 16 months to craft legislation on assisted dying. That apparently wasn't enough… the past 16 months leading to that deadline have taught us a lot about our political system and the men and women who represent us… it tells us a lot about the timidity of our elected representatives.… We shouldn't be here after 16 months… Blame our representatives who acted like lazy university students kicking the homework down the road under the Conservatives, then crammed during an all-nighter under the Liberals. (Toronto Star, Opinion, May 2016)

Discourse (Talk and Ideas)

14% of the *Fence-sitting* villain cast (across five articles) were talk or ideas. Two articles villainized as false the idea that forcing physician referrals is necessary to ensure access to MAID. Two articles villainized the problematic linguistic framing that structures illness within a "battle narrative." And one article characterized words as accidentally villainous, when the narrator described herself as "haunted" by words she once heard nurses say about her mother when her mother was in a coma ("Why are we keeping this poor woman alive?") before her mother made a surprise recovery, lived 20 more years, and watched her grandchildren grow up.

> Referral has been a hot-button issue… Blackmer said the CMA had proposed an alternative: the creation of a central information hub to facilitate access to doctor-aided death, which conscientious objectors could point out to patients who desired to terminate their lives… But Blackmer said the proposal was not even mentioned in the committee's report, despite having the backing of Dying With Dignity Canada and the B.C. Civil Liberties Association... "We're more than convinced that common ground exists," said Blackmer. "If the rationale for requiring mandatory referral is to ensure access, that's very much a false dichotomy. There's no need to require mandatory referral to ensure access." (Telegraph-Journal, News, Feb 2016)

Background Situation or State of Affairs

Fence-sitters occasionally (across five articles) framed the background situation or state of affairs as a mechanistic villain. Three articles vilified systematic deficiencies in Canadian healthcare, particularly systematic stigma that deprioritizes mental healthcare, and the inadequacy of palliative care (inadequate training, funding, and strategy). One article vilified as unsustainable the cultural state of low social connection and over-reliance on the healthcare system. Finally, one article vilified the "legal limbo" feared if the Supreme Court failed to extend the date at which its judgment would take effect.

> Here, it is worth returning to the Supreme Court of Canada's declaration in another case that "the mentally ill have historically been the subjects of abuse, neglect and discrimination in our society." This neglect has resulted in "years of underfunding of mental health," in the words of the Mental Health Commission of Canada… There is currently a systematic stigma in how we organize services and funding for people with mental health problems… provinces have yet to even publish wait time data for psychiatric care. (The Times – Transcript, Opinion, March 2016)

Frontline Healthcare Practitioners

Fence-sitters cast health workers as villains only rarely (across three articles). In two articles, ER doctors who stopped resuscitating solo suicide victims were framed as "negligent" (though mildly; due to presumption of confusion, action against these physicians was not proposed). A third article framed as villainous a doctor who in 1995 tried to assist the suicide of a depressed AIDS patient who survived and was later glad to be alive after counselling and soon-developed AIDS treatments.

> Robert, the college's secretary, told the National Post that an unspecified number of doctors were interpreting suicide attempts as an implicit refusal of treatment. They "refused to provide the antidote that could have saved a life. This was the real ethical issue," he said… "From a moral point of view, this duty to act to save the patient's life, or to prevent him from living with the effects of a too-late intervention, rests on principles of doing good and not doing harm, as well as of solidarity," it reads. "It would be negligent not to act." (Calgary Herald, News, March 2016)

Activists on Both Extremes

Fence-sitters characterized activists on both extremes as villains in three articles, though expressing sympathy to some degree for concerns expressed by both sides.

> Assisted dying, like abortion, is simply not an issue given to absolutes. (Indeed, Schouten blames the pro-life movement's often absolutist and unreasonable demands, in part, for the fact that it's so hard to argue for the sorts of laws that exist in Sweden and the Netherlands.) (Edmonton Journal, Opinion, Feb 2016)

> Creepily enthusiastic euthanasia activists aren't making me feel confident that we will end up with a balanced policy… doctor-assisted-death proponents are pushing the Trudeau government to bring in the least-restrictive euthanasia laws in the world... The euthanasia lobby is going too far in pushing such an extreme agenda. (The Province, Opinion, Mar 2016)

Ignorance and Naivete

In two articles, *Fence-sitters* included minor villainization of naivete among those critiquing the Liberal government for seeking a timeframe extension from the Supreme Court.

> The Liberal government is telling the Supreme Court of Canada that <u>those pushing for speedy implementation</u> of right-to-die policies are <u>naive about the legislative process</u>. (Waterloo Region Record, News, Dec 2015)

A Court That Issues Baseless or Vague Rulings

Two *Fence-sitting* articles vilified the court that decriminalized suicide assistance – not due to clear opposition to suicide assistance, but because of perceived flaws of procedure or execution.

> <u>In fact, it's complicated</u>. To start with, the <u>Supreme Court decision of February, 2015, is maddeningly vague</u>. It says that people with "grievous and irremediable" suffering are entitled to assisted death. How are we supposed to interpret that? "<u>The court was negligent in not telling us where the line is</u>," one person who is deeply involved with the issues told me. (The Globe and Mail, Opinion, Feb 2016)

The University Framed as Silencing a Professor

Two *Fence-sitting* articles included vilifications of the university framed as having "disappeared" and "silenced" a researcher who was investigating 'Nu-Tech Deathing techniques,' focusing only on an argument about university research.

> "Russel Ogden has <u>been successfully disappeared from this institution</u>," says Greg Jenion, a fellow KPU criminology professor. "The <u>administration has put a lid of silence</u> over [the matter]. They will not speak to it." As his supporters point out, Mr. Ogden has broken no laws and he's committed no crimes. They say he's <u>being silenced and pushed to the sidelines</u> by a <u>fumble-prone university administration that's reeling from myriad other controversies</u>… (National Post, News, Jan 2015)

System-level Healthcare Organization

Fence-sitters framed system-level healthcare organization(s) villainously in two articles, first critiquing Canada's medical system as inadequate at training in palliative care, and second reporting on reprimands given to a Dutch euthanasia clinic.

> Among the patients here was a woman with a pathological fear of grime and bacteria who had a washing obsession, as well as a 63-year-old man who feared loneliness after his retirement. In both instances, doctors here helped the patients to die…. The independent review commission

> recently reprimanded a doctor at the clinic who had provided assisted suicide to a 47-year-old mother suffering from a bad case of tinnitus. It faulted the doctor because, it claimed, "not all treatment options had been exhausted." It was the third reprimand for the clinic within a year. (Toronto Star, Feature, Feb 2015)

Heroes (According to *Fence-sitting Camp* Policy Narratives)

28% of the *Fence-sitting Camp*'s cast (across 29 media articles) were hero characters. In descending order of frequency, heroes as cast by the *Freedom* narrative included:

Country, Government, or Politician

39% of *Fence-sitting* heroes were framed to be country, government, and politicians when they move at the right pace or with the appropriately reflective approach. The 'right pace' usually meant slowly and cautiously – to get an important issue 'right' while balancing multiple priorities – but in one case praised Quebec for accelerating the conversation. One-off heroes in this category were framed as including: a blind politician said to help disabled persons feel safe by his presence at the table; B.C. for a network of MAID coordinators protecting doctors from referral pressure; Oregon for committing to universal hospice and palliative care at the same time as MAID; two Canadian provinces praised by their representatives as transparent and ready; the Senate for voting diversely; and in a mostly off-topic story, politicians who at least work warmly together on other issues, if not MAID.

> Quebecers are not afraid to have discussions that the rest of the country sometimes is afraid to have. It's an open society that really does not have trouble discussing difficult issues. Quebec may have accelerated the discussion quicker than the rest of the country is prepared to do. But Quebec should be proud. (The Gazette, News, Nov 2013)

Frontline Healthcare Practitioners

36% of *Fence-sitting* heroes were health workers, mostly in their caring role and sometimes performing additional duties (such as assisting in policy development). *Fence-sitters* mostly praised health workers as praiseworthy by virtue of good intentions, without narratively judging whether they should perform MAID. One *Fence-sitting* article heroized a palliative care provider (also a CMA-awardwinning bioethicist and university lecturer) willing to endure sleepness nights to help develop a "safe system" for MAID (as an appointed official) while personally opposed to its legalization.

> Dr. Francescutti, the CMA president, said the take-home message is that regardless of how things play out in the courts, or how public opinion changes, "Canadian physicians will always be there for their patients at this most difficult time, at the end of life." (The Globe and Mail, News, Aug 2014)

Public or People in General

19% of *Fence-sitting* heroes (across six articles) were framed as being the profession non-specific public who: care for patients like they'd care for a loved one; act cautiously; help fund palliative care; engage in conversations about mobilizing communities to care for members; advocate to improve medical/social supports for the vulnerable; acknowledge valid reasons for concerns about euthanasia; or support the distraught by compassionate presence rather than just advocating to make suicide harder for them.

> Clearly, whatever comes out of this conference, we all need to be part of the conversation about how to mobilize communities to care both for the aging and dying, and for their natural caregivers. (The Ottawa Citizen, Opinion, Nov 2016)

Family or Friends who Caregive

Two articles arguably framed family and friends as heroic insofar as they caregive (an implicitly heroic act), though the tonal emphasis was on the burden of this, not praise due.

> In fact, natural caregivers such as family, neighbours and friends are shouldering a significant burden, with 46 per cent of Canadians reporting to Statistics Canada that they have cared for a friend or family member with long-term health, age or disability issues. Among Canada's natural caregivers, about 28 per cent have tended to terminally-ill care recipients. (The Ottawa Citizen, Opinion, Nov 2016)

Moral of the Story (According to *Fence-sitting Camp* Policy Narratives)

Fence-sitting story morals (propositions from the *Fence-sitting* narrative perspective about "what should happen") occurred in 74 documents (24.7% of documents). According to *Fence-sitting Camp* narratives, in descending order of frequency:

	Something should be done about…	Pg.
18%	Discourse	127
15%	Political Activity	128
14%	Patient Experience	128
11%	Safeguards	129
10%	Healthcare System	130
9%	Baseline Legal Activity	130
6%	Health Workers	131
4%	Oversight	131
3%	Access Categories	132
3%	Conscientious Objection Rights	132
3%	Deference due Courts	132
2%	Other Rights	133
1%	Deference due Government	133
1%	Deference due *Elected* Officials	134

Discourse (Words and Conversation)

18% of *Fence-sitting* story morals argued to do something about words and conversation. Five articles argued that Canadians should talk more in private conversations (e.g. discussing end-of-life preferences with doctor and family, and establishing advanced care plans). Four articles argued to avoid 'dangerous' talk like: framing end-of-life around euthanasia before first having a "robust discussion about end of life" in other ways; having 'too-soon' conversation about MAID organ donation (a risk to public trust); and calling for nationwide hearings before doctors decide they're willing to participate. Three articles argued that public discussion should inform government officials. Three articles argued for discourse about a university researcher who should be allowed to 'talk' (research) about still-illegal activities. Two articles argued to reframe conversation from battle rhetoric. Two articles argued that doctors should "get used to" talking about MAID (in public/with patients). Other 'let's talk' articles ranged from calls to: talk about the impact of MAID on doctors; talk about potential inconsistency between legal suicide assistance and illegal suicide counselling; keep language clear; encourage reflection on improving autonomy *beyond* legalizing MAID; and increasing awareness of existing options and the importance of private legal directives. Finally, the Canadian Medical Association (CMA) wanted their voice 'at the table' if MAID were legalized.

> In a report released Tuesday in Ottawa, the Canadian Medical Association (CMA) also said the public, politicians and policy makers need to engage in a national dialogue about end-of-life issues, including discussions about such controversial topics as euthanasia and physician-assisted death. The authors also strongly encourage individuals to talk to loved ones about their wishes regarding death, including a written advance care directive that clearly spells out how they want to spend their final days. (Trail Times, News, June 2014)

Political Activity

15% of *Fence-sitting* story morals argued for political activity. Five articles argued the government should speed up crafting law, while three articles included the (government's) argument for a 6-month extension. Two articles simply argued the government should indeed craft replacement law (in contrast to using the 'notwithstanding' clause or allowing legal limbo). One-off story morals argued that: politicians should be careful when appointing judges; elected politicians (not unelected officials or courts) should make law; the government should enhance clarity about the court's intention; the government is right to cautiously create "a high hurdle to obtaining a state-sanctioned, assisted death;" and the MAID debate should be parliamentary (not public referendum).

> In a submission to bolster its request for a six-month extension, the government says implementing a landmark decision on physician-assisted dying will require full parliamentary consideration as well as provincial legislation. (Waterloo Region Record, News, Dec 2015)

Experience of Prospective MAID Recipients; Response to Suffering

14% of story morals in *Fence-sitting Camp* narratives argued that suffering, or about the experience of prospective MAID recipients, beyond simply performing or withholding MAID itself. To enhance experiences: seven articles argued to protect vulnerable persons from abuse or pressure towards MAID; six articles argued to improve access to quality palliative care; four articles argued to improve/ensure pain management; three articles argued to alleviate fear (of pain, loneliness, or being a burden); two articles argued to improve provision of Canadian mental healthcare; two articles argued to attend to unspoken needs; two articles argued to address other factors impacting aging/health (e.g.

poverty alleviation and increasing community support of caregivers). Finally, one *Fence-sitting* story moral challenged both *Freedom* advocates and *Protectors* to think beyond what the law permits or prohibits:

> As we reflect on the implications of the court's decision, we also need to recognize that a commitment to fostering the personal autonomy of Canadians requires more than just a repeal of criminal sanctions on assisted suicide…. This point is as pertinent for assisted suicide skeptics as it is for supporters. If one is committed to ensuring that every person feels like he or she can and should go on living, then just trying to prevent them from receiving assistance in dying is not adequate…. A change in law signalling a reconceptualization of mercy killing as medical aid in dying obligates us to think about our own personal implication in elaborating the conditions necessary for people to make truly autonomous decisions. This is a function not just of absence, but presence. Removing chains on those confronted with "the cruel choice" of whether to go on does not provide sufficient conditions for their exercise of liberty. Gentle touch, helping hands, loving eyes and kind words - our presence - is just, if not more, vital. (Chronicle – Herald, Opinion, Mar 2016)

Safeguards

11% of *Fence-sitting* story morals (across 12 articles) advocated in favour of safeguards to accompany MAID law. Six articles proposed mandatory psychiatric assessment before each MAID event (one article hoping for assessment also of social, existential and spiritual motivators). Three articles advocated for 'strong' but unspecified safeguards to protect the mentally ill, children, or anyone from duress. One story moral advocated screening for undue influence and verifying informed consent. One story moral called for legislative restrictions to protect persons with PTSD or adapting to new disabilities. Finally, one story moral advocated to forbid organ donation for MAID-choosers (to prevent inadvertent added pressure towards choosing MAID).

> Concerns backed up by this study from the Netherlands. Researchers studied cases of 66 patients, mostly women, discovering they had been euthanized not just for depression, but also schizophrenia, eating disorders, even autism, all illnesses that may affect cognition… Yet in 11 percent of deaths there was no independent psychiatric assessment, and in a quarter of cases physicians disagreed on whether the patient qualified, but the death went ahead anyway… so the message to those now drawing up Canada's laws, will the mentally ill be allowed to request physician-assisted suicide, and if so, what safeguards will be put in place to avoid the problems that are being identified in other countries. (CTV National News, News, Feb 2016)

System-level Healthcare Organizations

10% of *Fence-sitting* story morals made arguments about system level healthcare organizations. Four articles argued for improvements to palliative care/access. Two articles argued for palliative-specific facilities to avoid MAID as a philosophical incompatibility issue. Two articles argued for better pain management in Canada (one proposing a National Pain Strategy). One story moral argued for systematic improvements to Canadian mental healthcare before expanding MAID to the mentally ill. One story moral argued to reduce dependence on the strained formal healthcare system, mobilizing communities to care for each other. And one story moral argued for a national oversight body.

> Goertzen said in addition to offering protections for both patients and caregivers, there must be a boost in palliative care "to ensure that people don't feel that there are no other options" to assisted death. "That would be the worst of situations," he said. (Winnipeg Free Press, News, May 2016)

Legal Activity

10% of *Fence-sitting* story morals made arguments about legal activity, mainly proposing that time be invested in constructing thoughtful laws (three articles), and laws must be clear – especially about who may kill and under what circumstances (two articles). Two story morals suggested that public feedback should inform MAID law (in one case suggesting referendum). One-off story morals were sometimes at odds, debating whether solo MAID court applications should be public (the media's request) or private (the judge's decision. One article suggested decriminalization *may* be appropriate in future but shouldn't be the focus today; and one article argued that laws should generally be "modest" and not go as far as the furthest-reaching-people want.

> If an extension is requested and granted, Wilson-Raybould suggested the issue will be placed before an all-party parliamentary committee, "to proceed on this extremely sensitive issue with openness and transparency. Thinking about the circumstance around ending a human life is pretty substantive to say the least, and the social and moral policy around that needs to be extremely considered." (The Ottawa Citizen, News, Nov 2015)

Frontline Healthcare Practitioners

6% of *Fence-sitting* story morals argued for action about health workers (beyond conscientious objection rights). Two articles argued that emergency room doctors should still resuscitate victims of solo suicide attempts. Two articles advocated providing doctors with clear training in *how* to perform MAID competently, to avoid “horror stories” like “botched executions in the U.S.” Two articles included arguments that a new provider category should perform MAID to keep regular physicians uninvolved, though one story moral included a counter-argument against specialized euthanists. And one story moral argued that physicians should lack anonymity about MAID performance in court (this narrative promoted by the lawyer for news media objecting to a judge’s publication ban).

> If philosophers believe assisted death is a positive development, and helping people to die would reflect well on their profession, then maybe they should be the ones to do it. "Lethal injection is a technically uncomplicated procedure that philosophers could easily learn to perform. It is already employed in several United States jurisdictions as a means of capital punishment without the aid of doctors." … Physicians have long argued that helping people die is contrary to their ethics and the ancient oaths of their profession. … "It doesn't take 10 years of medical school to learn how to do this," says Dr. John Patrick, an Ottawa physician and researcher who now lectures on ethical issues in medicine. "I suggest it should be lawyers or politicians. And I'm only half-joking." … Lemmens has other concerns about euthanasia specialists, including practitioners who are overly enthusiastic about their work or stand to profit from it. "What do we do when people develop this kind of professional zeal? What if there is fee-for-service?" he says. "We would want to make sure that there are no improper incentives." (The Ottawa Citizen, Opinion, Oct 2016)

Oversight

4% of *Fence-sitting* story morals argued about oversight. Two articles argued that death certificates should reflect MAID as the cause of death, while one story moral argued to keep lethal injection off death certificates. Two articles argued generally for careful oversight and evaluation of MAID; one of these called for the creation of a “national oversight body”. Finally, one article conveyed both sides of an argument between news media and a judge, with the news media seeming to argue that publishing MAID-performer names is an important oversight measure, and the judge arguing to preserve anonymity to avoid spooking health workers from participation

> Under its proposed national framework, CMA is recommending creation of a national oversight body, safeguards to protect the vulnerable and freedom for doctors who refuse to participate in assisted dying on moral or religious grounds. (Leader Post, News, June 2015)

Categories of Access to MAID

3% of *Fence-sitting* story morals expressed conditional opposition to category expansion. While not ruling out eventual expansion (e.g. to children, advance directives), two articles argued to first be 'modest', and learn from experiences of MAID within a restricted group. One article argued that MAID is so high-stakes and distinct from other choices that the state should *never* sanction expanding it to minors… except on a "case by case" basis reviewed by a court. (See Narrative Strategy.)

> Our biggest choice is whether we want to be more like Oregon, or more like the Netherlands and Belgium. Oregon's law is highly restrictive. … The Netherlands and Belgium take a far more expansive approach…. In the middle is Quebec… The right-to-die lobby is vocal and persistent. It will likely push for the broadest possible interpretations of the law, whatever it turns out to be… For now, I think we should be modest. A law that some people think doesn't go far enough is probably the one we want. (The Globe and Mail, Opinion, Feb 2016)

Conscientious Objection

3% of *Fence-sitting* story morals proposed general respect for the conscientious objection rights of doctors (one article explicitly included the right not to refer). One article argued in favour of a mechanism (central information hub) to bypass the perceived need to involve objecting doctors.

> The CMA, which represents about 80,000 physicians across the country, had argued during hearings to the committee that doctors who oppose assisted dying on grounds of conscience should not be required to refer patients to a colleague willing to provide or administer drugs that would end their lives… [proposing] an alternative: the creation of a central information hub to facilitate access to doctor-aided death. (Telegraph-Journal, News, Feb 2016)

Deference due Court or Law

3% of *Fence-sitting* story morals mildly suggested that courts should have neither primary nor final role in establishing law. One article made the general argument that courts should not be activist (i.e. should defer to role boundaries constraining them to work within existing law rather than try to create new law). One article included a politician’s promise to vote on Bill C-14 according to a referendum (implicitly suggesting that law should be formed according to interpretive preferences of electors, not of Supreme Court members). And one article advocated that politicians *consult* constituents and *consider* feedback while writing new law, instead of simply incorporating a court’s recommendations or presumed intent into law.

> Mr. Schmale himself has launched a constituency referendum on Bill C-14. "With issues of this magnitude, I believe the people of Haliburton-Kawartha Lakes-Brock deserve to have their opinions heard directly. As such, I am asking the people of this riding how I should vote on this Bill through a constituency referendum," stated Mr. Schmale. "I want their honest opinion; I will vote according to the majority of votes cast in this referendum." (Kawartha Lakes This Week, News, May 2016)

Other Rights

2% of *Fence-sitting* story morals argued for rights beyond conscientious objection, proposing a Canadian right to palliative care and resources, and respect for unspecified rights of non-atheists.

> We live in a pluralistic democracy. As much as they would wish it, the views of atheist secular humanists aren't the only ones to consider, even with the Supreme Court decision.. I understand why people want euthanasia, now declared a Charter right by our highest court. I just hope other people's rights will be respected and that the procedure will be limited to hopeless cases. (The Province, Opinion, Mar 2016)

Deference Due to Government (General)

One *Fence-sitting* story moral argued that democracy should involve more deference to accountable representatives, and less use of public referenda, as a general rule.

> Especially in these kinds of circumstances, the debate that leads up to a referendum can ride roughshod over the rights of minorities… Parliamentary debate is a different kind of process. Debates are a matter of public record and representatives are accountable for their comments. In well-functioning democracies, parliamentarians - not always but often - work to find solutions that serve the interests of the majority but simultaneously protect the rights of minorities. The debate on the right to assisted death in Canada was an example of exactly that kind of debate.. (The Globe and Mail, Opinion, July 2016)

Deference Due to Elected Officials

One *Fence-sitting* story moral argued that a “bigger problem” is that Canadian laws should be made by elected representatives, not by “the courts” or by “an unelected Senate”.

> Senators voted 41-30 on Wednesday to amend Bill C-14, to allow suffering patients who are not near death to seek medical help to end their lives. The change, if accepted, would delete a requirement that a person's natural death be reasonably foreseeable, removing the central pillar underpinning the legislation. … Ambrose says it also circumvents the will of the elected House of Commons… "We have the courts making laws in this country and now we have an unelected Senate changing the laws of an elected House," Ambrose told a news conference Thursday. "There's even a larger debate here, which I think is upsetting a lot of my constituents and a lot of people across the country." (Prince Albert Daily Herald, News, June 2016)

Narrative Strategy (According to *Fence-sitting Camp* Policy Narratives)

The *Fence-sitting Camp* recurringly employed four main narrative strategies: Adopting the positionality of an undecided judge; emphasizing procedure more than outcome; emphasizing private action over legal action; and employing a narrative tone of caution.

Adopting Positionality of an Undecided Judge Reviewing a Complicated Case

Fence-sitting narratives strategically adopted the positionality of an undecided judge reviewing a complicated case. This involved discursively framing oneself as modestly acknowledging the limitations of one’s own expertise and waiting to follow as-yet-unseen evidence to any conclusion. The questions surrounding euthanasia legalization were recurringly framed by *Fence-sitters* as too complex for easy answers; and both sides were framed as bringing evidence to the table.

> A handful of countries or states have legalized assisted-suicide, and their experience provides evidence to support both sides of this argument: That it is the humane thing to do, respecting the rights and autonomy of competent persons in pain; and, that it is a slippery slope endangering the lives of those most vulnerable -- the disabled, the very old and the very young… The Harper government… should get started on the long, hard work of consulting citizens to find a made-in-Canada position on an issue that repeatedly has entangled the most learned of jurists and philosophers. (Winnipeg Free Press, News, Aug 2014)

Emphasizing Procedure More Than Outcome

Fence-sitting narratives strategically focused on procedure more than outcome, proposing guiding principles or standards rather than announcing a belief about what these should lead to. When a baseline *Fence-sitting* narrative seemed to express opposition to a policy outcome (e.g. opposition to expanding MAID access to children), the narrator would often walk back this back, reframing their concern as potentially addressable through appropriate procedures.

> "Setting the precedent that the state is going to tolerate killing children, even mature minors, is very, very dangerous," Arthur Caplan, head of medical ethics at New York University's Langone Medical Center, said Tuesday… "It's the slippery slope argument, and this is a slope I worry about. Sometimes I don't, but this one I do." … "When you're talking about killing children - killing them - we need independent confirmation," Caplan added. "I'm not saying no kid could do it. But I am saying I would want a court review - case by case by case." (Leader Post, News, Dec 2015)

Focusing on What Individuals Can Do in Private Lives, Not Waiting For Euthanasia Law

Fence-sitting narratives sometimes avoided arguing about legal policies by focusing on the private life sphere of activities (for example, healthy eating to prepare for healthy aging). Interestingly, it was often politician narrators who redirected conversation to individual-level actions. Such narratives didn't rule out eventual government policy, but suggested individuals first prioritize actions in their private lives (especially maximizing their own health and conversing with family).

> End of life actually starts at the beginning of life. The healthier we are the healthier we die. The best death would be living a full life - and you can do that by doing three simple things: don't smoke, exercise (take at least 10,000 steps a day) and get proper nutrition. If you do that, chances are good you're going to lead a pretty healthy life and then drop dead at some point, which is probably old age, and ideally have no contact with the health care system. If you are diagnosed with a condition that suggests you're going to die earlier - cancer, heart disease, or chronic pulmonary condition - then you should start talking with family about your expectations in the final days of your life. (The Gazette, News, Nov 2013)

Tone of Caution: Let's be Careful not to Wrong People in Peripheral Ways.

Typically, *Fence-sitters* strategically adopted one of two narrative tones. An exuberantly harsh tone emerged when critiquing perceived procedural wrongdoing (usually political procedure). A tone of sombre caution emerged with discussing proposed practices deemed 'risky', such as expanding MAID to traditionally vulnerable persons. *Fence-sitting* narratives were at times near-indistinguishable from *Protection* narratives except for avoiding simultaneous comment about baseline MAID legality.

> But the prospect of combining two separate requests – doctor assisted suicide and organ donation - is creating profound unease for others. Some worry those contemplating assisted suicide might feel a societal pressure to carry through with the act so that others might live, or that it could undermine struggling efforts to increase Canada's mediocre donor rate. "Given the controversy and divided opinion regarding physician-assisted suicide in Canada, I don't think we are anywhere near being ready to procure the organs of patients who might choose this path," said Dr. Andreas Kramer, medical director of the Southern Alberta Organ and Tissue Donation Program in Calgary. "I think there is a legitimate possibility that advocating aggressively for this could compromise the trust that the Canadian public has in current organ-donation processes," Kramer said. (Calgary Herald, News, Mar 2015)

Chapter 7: (Plot) Summaries of Findings

Freedom Camp *Policy Narratives*
(promote laws enabling suicide assistance / active + direct euthanasia)

Vs.
Protection Camp *Policy Narratives*
(promote laws prohibiting suicide assistance / active + direct euthanasia)

Vs.
Fence-sitting Camp *Policy Narratives*
(avoid promoting either baseline legal status; focus on peripheral issues)

In this chapter, I provide condensed four-page executive summaries of the three different narrative policy positions in Canada's euthanasia debate (2007 – 2017). I briefly summarize the plot of each narrative policy camp (*Freedom* vs *Protection* vs *Fence-sitting*), weaving together the setting, characters, morals of the story, and narrative strategies into three separate 'stories' as collectively expressed by the respective policy camps. These are dramatically condensed summaries of each plot, drawing together narrative elements from policy camp narratives as told across the random sample of 300 media articles analyzed. Many details are (naturally) omitted from these condensed summaries, and the individual media articles from which these narrative elements are sourced would not each include every narrative element mentioned. The reader would do well to bear in mind the complexity of narrative content present within the original media articles from which narrative elements were extracted and associated with each narrative "camp," and the different frequencies with which a narrative element recurred, as expanded upon in the preceding three chapters. Recall that the gathering of narrative data into clean-cut narrative "camps," and idealized narrative element subcategories, is, in the first place, a heuristic device meant to aid analysis. The very language of a "plot" itself – typically implying the intentionality of a single author – is heuristic here also, since the narrative elements – narrative threads – here woven together are from many speakers, who may not individually intend what is spoken by another. For the purpose of this research, I am treating the 'plot' of each story as that which could be interpreted by a reader synthesizing the content of multiple narratives into one continuous, coherent story, rather than suggesting that any one contributing narrator may intend every element contributed by other narrators.

With this in mind, I revisit the characteristic by which a narrative element became associated, by my methodological process, with an overarching policy narrative 'camp': the inclusion of a story moral about the baseline legal status of suicide assistance and/or active + direct euthanasia. If a narrative clearly advocated baseline legality of suicide assistance and/or active + direct euthanasia, then that narrative – including all other story morals and narrative elements it contained – was grouped into the *Freedom* policy narrative camp. If a narrative clearly advocated baseline prohibition of suicide assistance and/or active + direct euthanasia, then that narrative – including all other story morals and narrative elements it contained – was grouped into the *Protection* policy narrative camp. Finally, if a narrative avoided adopting a clear advocacy position in favour of either baseline legal status, then that narrative – including all other story morals and narrative elements it contained – was grouped into the *Fence-sitting* policy narrative camp.

The following, then, are these stories.

***Freedom Camp Policy Narratives*: A Story about Freedom, Equality, and Progress**

In Canada (pre-2015), suicide is not criminalized but assisting suicide is criminalized. According to *Freedom* Camp policy advocates, Canada must decriminalize the assistance of suicide to allow equal access to suicide for people who are physically incapable of performing the life-ending action themselves (especially so that people needn't kill themselves too soon, from fear of later losing capacity). *Freedom* advocates argue that morally equivalent but experientially inferior ways of accelerating death (such as withdrawing life support) are already legal in Canada, and that the fastest and most certain "gentle exit" from life is lethal injection (like we provide for beloved pets).

The *Freedom* Camp argues that we should therefore prioritize legalizing lethal injection – and that we should stop debating about whether or not to do this, but accept that we will inevitably do this, and move the debate along to discussing details of what legalization should look like. The conversation, according to the *Freedom* camp, needs to be reshaped to avoid stigma by avoiding words such as "suicide" or "euthanasia", and instead referring to this end-of-life choice as "dying with dignity", or by medicalized language reinforcing perception of the procedure as a basic "health care service" like any other: "Medical Assistance in Dying" (MAID). The *Freedom* Camp argues that while there should indeed be safeguards in place to prevent abuse (with potential safeguards unspecified, typically commenting that relevant experts will surely come up with effective safeguards), these safeguards should *not* include mandatory psychiatric assessments of people applying for MAID, which is framed as inappropriate gatekeeping.

Freedom Camp advocates argue that the freedom to choose MAID (framed as dying at a time and in a manner of one's own choosing) should be considered a basic human right: the 'right to die'. Once this 'right became recognized' in law for terminally ill adults (2015 onward), they argue that it would be unjust discrimination to fail to expand MAID access to others, especially: those whose death is not otherwise reasonably foreseeable; dementia patients who signed advance directives; minors; and the mentally ill. The *Freedom* Camp narratively frames those who oppose MAID (or oppose expanding MAID) as arrogantly trying to impose their views of what suffering others should consider tolerable, describing those who suggest that MAID will lead to harm of the vulnerable as foolish fearmongers falling for the 'slippery slope' fallacy.

According to *Freedom* Camp policy advocates, legal evolution in Canada is too slow, and Canadian politicians in majority governments systematically tilt conservative regardless of party, being unduly influenced by disproportionately powerful religious minorities who ignore suffering and want to impose their unmerciful views on not only their own followers but on everyone else too.

Fortunately, the *Freedom* Camp argues, the Canadian public are more open-minded and savvy than their representatives, consistently telling pollsters they support MAID legalization. Quebecois secularists, British Columbian ecospiritualists, liberal religious and religious 'nones' have notably led the push to legalize MAID. This particularly includes those of the baby boomer generation who are accustomed to controlling and customizing life experiences, who have watched their parents' generation die in ways they found disturbing, and now fear what their own approaching deaths will look like. The non-traditional and progressive values of these groups have already largely been affirmed by Canadian society (e.g. contraception; abortion; divorce; same sex marriage) and MAID is framed by the *Freedom* Camp as just one more inevitability of progress, to be accepted and celebrated like other progressive practices. These narratives appeal to a patriotic/national sense of identity patterned after progressive values, promising that Canada will prove itself a nation worthy of being proud of when it heroically follows the lead of progressive regions like the Netherlands and Oregon, whose example – *Freedom* Camp advocates argue – shows MAID legalization to be safe and positive. According to the *Freedom* Camp, the 2015 Canadian court that declared the Criminal Code ban on assisting suicide 'unconstitutional' demonstrated excellent logic in dismissing the concerns of anti-euthanasia activists as frivolous. *Freedom* Camp advocates argue that Canada's politicians and citizens must now abide by this court's judgment, and should not seek to overturn it. In drafting a replacement law to officially legalize MAID, *Freedom* Camp advocates argue that politicians should respect the implicit intent of the court and the will of the people, to enable broad access to MAID with minimal or no restrictions. Ethicists and doctors who are personally opposed to MAID should, according to *Freedom* Camp narratives, be removed from government appointments and committees devoted to developing guidelines for the safe implementation of MAID, since their personal opposition is argued to give the appearance of bias.

Finally, doctors are framed by *Freedom* Camp narratives as an inherently trustworthy group of people with the expertise and moral uprightness to help develop and follow guidelines for MAID. In *Freedom* Camp narratives, doctors are framed as heroically compassionate when they perform MAID (before and after decriminalization), framed as suffering when prevented from helping patients through performing MAID (or suffering when punished by oversight committees who second guess their good-faith decision to perform MAID), and as burdened by the complicated bureaucracy and social disapproval surrounding MAID. To ease the burden on doctors already participating (and to enhance access for patients), *Freedom* Camp advocates argue that bureaucracy should be streamlined, financial compensation for performing MAID should be increased, and more doctors should 'toughen up' and start performing MAID, instead of selfishly opting out and 'cruelly forcing patients to suffer'. *Freedom* Camp advocates argue that doctors should recognize patient rights as outweighing doctor rights, proposing that conscientious objection rights should be clearly restricted such that doctors have no choice but to at least provide effective referrals for MAID. At the institutional level, palliative care centers and hospices are minimally mentioned in *Freedom* Camp narratives as ("of course") heroic and the "bedrock" of end-of-life care, with agreement, typically in brief, that ("of course") access to good palliative care should be improved. At the same time, and more emphatically, *Freedom* Camp advocates argue that regardless of good care options, MAID access will always be necessary, with the 'freedom to choose' framed as a good in itself. This policy camp proposes that hospices and palliative care centers should improve themselves by offering MAID onsite among their range of services. Indeed, *Freedom* Camp advocates argue that healthcare institutions that receive public funding should have no legal right to conscientiously object to the performance of MAID on their premises, contending that institutions that 'cruelly and inappropriately' prohibit MAID on their premises (requiring patients to be transferred to another location to receive MAID) should lose public funding. Finally, *Freedom* Camp advocates suggest that individuals should stop donating privately to organizations that fail to support MAID, and should instead donate to MAID-supporting organizations.

Protection Camp Policy Narratives: **A Story about Vulnerability, Protection, and Supportiveness**

Protection Camp advocates propose that Canadians have been negatively impacted both by cultural avoidance of discourse about death (leading to widespread lack of awareness about existing end-of-life options and how dignified death can already be), and by euthanasia activists' exploitation of this ignorance to promote a false assumption that legalizing lethal injection is necessary to avoid pain or other feared experiences. *Protection* Camp narratives frame euthanasia activists as pushing an ableist "death before disability" discourse which frames dignity as losable and increases fears about eventual dependence or disability. *Protection* Camp advocates also describe Canadians as impacted by geographic and socioeconomic inequities in access to good quality palliative care and mental health treatment, arguing that we should be focusing our energy on improving provision of these real resources instead of legalizing lethal injection that invisibilizes inadequacies of care.

Instead of making supported-care alternatives to suicide available, *Protection* Camp advocates argue, vulnerable patients are placed at further risk of harm when a necessary safeguard to protect them from abuse or pressure to suicide – the absolute legal prohibition against third party assistance of suicide – is removed. Those framed by *Protection* Camp advocates as vulnerable patient victims particularly include: the mentally ill; socially isolated; disabled; children; cognitively compromised; poor; Indigenous youths; abuse victims; uncommunicative or non-consenting persons; and anyone who might be neglectfully made to feel like an inconvenient burden then discouragingly offered access to "die well" rather than adequate support to live well. *Protection* Camp advocates argue that evidence from historical and contemporary foreign jurisdictions shows that the slippery slope is real and happens today, with legalized euthanasia having slipped free from its original restraints and now being treated as a trivialized "best way to die", going under-reported, performed without explicit request, and performed in cases considered "off the rails" even by those who originally pioneered legalization. Grieving family members who are unwilling survivors of their loved one's suicide have spoken up as *Protection* Camp advocates, entreating Canada to avoid smoothing paths to suicide, so that others will not have to suffer what they suffer. In *Protection* Camp narratives, those who would try to forbid people with disabilities (or their advocates) from talking about the history and dangers of euthanasia, or who condemn such speech as "strident", are described as sowing fear that the lessons of history have not been learned and will instead be repeated. The law against assisting suicide is framed by *Protection* Camp advocates as having been rightfully upheld by Canada's Supreme Court of 1993 as proportionally necessary to protect the vulnerable, and as constitutional and consistent with Charter rights, with this an issue that should not be reintroduced. *Protection* Camp advocates argue that laws should be structured to prevent collateral consequences and should be careful to send messages that bolster society's appreciation for the sanctity of life, not erode it. They argue that good law cannot be made from hard cases, and that a court would be naïve to think that lethal injection can be legalized for some without "terrible ramifications" for others.

After the law against assisting suicide was decriminalized in 2015 (according to *Protection* Camp advocates, misguidedly decriminalized by an activist Supreme Court appointed by irresponsible politicians), *Protection* Camp advocates argue that it should be recriminalized. Disability rights advocates, doctors, and religious communities (framed as having a responsibility to share their values and insights formed through centuries of care for the suffering) are encouraged by *Protection* Camp advocates to now be defiant, and fight to appeal this 'unjust' law. It is argued to not be a time for collaborating on a replacement law which implicitly gives up on appeal. *Protection* Camp advocates appeal to elected government officials to 'carefully consider the evidence' presented to them; propose that these officials should be allowed to vote their conscience on this issue rather than forced to "toe the party line"; and propose that these officials should use their available legal mechanism of the 'notwithstanding' clause to correct the 2015 court's 'error' and restore the law against assisting suicide.

Once parliament instead made itself – from the *Protection* Camp perspective – 'complicit in the court-led down spiral' by enacting the court-prompted replacement law in 2016 (legalizing and regulating both suicide assistance and active + direct euthanasia as 'MAID', albeit under restricted circumstances), *Protection* Camp advocates argue that the criteria by which a person qualifies for MAID should stay restricted. *Protection* Camp narratives especially contend that: MAID should never be expanded to the mentally ill, children, or the newly disabled; MAID should not be performed on anyone whose death is not otherwise reasonably foreseeable; and MAID should not be performed on anyone who cannot competently consent at the time of MAID, meaning no MAID by advance directive. Further, *Protection* Camp narratives comment that Parliament must enact "stringent" safeguards and oversights in law to protect the vulnerable from abuse in this new context of legal MAID (although specific safeguards in a MAID-legal environment are little-proposed by this camp which considers legal prohibition a minimum necessity), and to preserve public trust and confidence in medical personnel and institutions. "All-in" euthanasia activists, who push for the removal of safeguards and the expansion of euthanasia to children and non-competent persons (arguing that anything short of this will be found unconstitutional) are framed by *Protection* Camp advocates as dangerously misguided to so constantly wear away at safeguards and protections for the vulnerable. *Protection* Camp advocates ask politicians and the public to stay open-minded to evaluating future evidence that may prove state-sanctioned lethal injection a mistake and require restoration of the law against it.

Finally, *Protection* Camp narrators argue that health workers must be protected from coerced conscription as "death squads" or "suicide enablers" when for reasons of conscience or psychological distress they cannot participate in MAID. Indeed, from the perspective of *Protection* Camp advocates, health workers *should* conscientiously object to MAID, and in a country where health workers may legally choose to perform MAID, patients should be empowered to identify and choose to receive care only from life-affirming health workers they trust to help them cope with diminished autonomy, rather than being forced to depend for care on doctors they distrust based on the doctor's openness to killing them as a "healthcare" act perceived by the doctor as in their 'best interests'. *Protection* Camp advocates argue that health workers overwhelmingly want and should retain the right, protected by an oversight committee, to conscientiously object to participation of *any* form in killing a patient through MAID, including the right to abstain from the complicity of referral for MAID, without fear of losing their medical license. Healthcare institutions (especially religiously-run hospitals, or hospices grounded in principles incompatible with MAID philosophy) should, *Protection* Camp narratives argue, have the right to prohibit MAID onsite, instead transferring patients to a MAID-providing institution if requested. *Protection* Camp narrators suggest that it would be ignorant to imagine that relying on public funding means an institution doesn't also rely on private funding, and propose that it would cause disproportionate damage to the public good to strip public funding from an institution's life-saving and palliative care services just because an institution declines to also participate in MAID.

Fence-sitting Camp Policy Narratives: **A Story about Complexity, Procedure, and Caution**

Fence-sitting Camp policy advocates propose that while we might not agree about how to proceed, it seems clear that patients deserve sympathy both because of any underlying condition which causes them so much suffering that they desire MAID, and because of any heightened vulnerability to abuse when MAID is legal. *Fence-sitting* Camp advocates ('Fence-sitters') argue that we can all agree that we want people to have pain-free, dignified "good deaths" – and at the same time, the world is too complicated (morally, socially, and with regards to the concrete realities of institutions and unintended side effects) for quick or obvious answers that will satisfy activists of either 'extreme'. It is framed as not-obvious, in *Fence-sitting* Camp narratives, that either a complete ban on euthanasia, or expansive permissiveness of euthanasia, is the most appropriate path forward. (And it is framed as not-obvious that the most important arena for action is focusing on what the law permits or prohibits.) *Fence-sitters* agree with other camps that this conversation seems to be occurring now because baby boomers are facing mortality at the same time as artificially life-sustaining technology has become widespread, and questions about withdrawal of unwanted treatment and the 'right to die' by active + direct euthanasia ('MAID') are being wrestled with simultaneously instead of delineated as separate issues. Canadians are framed in *Fence-sitting* Camp narratives as divided over whether MAID should be legally permitted – suggesting that despite claims of entrenched advocates, there is not unanimous support in either direction – but as *united* on the need to improve palliative care (with 70-85% of Canadians lacking access to palliative care and Canada ranked low in end of life care globally), and as united on the need to have better conversations about end of life in general.

Fence-sitters advocate that Canadians and their doctors should start talking more, both in private conversations (discussing end of life concerns and preferences), and in public forums (engaging in the public debate or being consulted by government officials for their thoughts). However, certain kinds of talk are framed by *Fence-sitters* as dangerous and to be avoided; for example: framing end-of-life issues around euthanasia *before* first having a "robust discussion about end of life" in other ways; having too-soon conversations about organ donation by MAID recipients that might shake public trust; or calling for nationwide public hearings before doctors have even decided whether they'd be willing to participate in any proposed practice. *Fence-sitters* suggest that conversation should: address the impact of MAID on health workers; address the potential inconsistency of legalizing the assistance of suicide while keeping the *counselling* of suicide a crime; keep language clear; brainstorm ways to improve the autonomy of patients *beyond* simply legalizing MAID; and increase awareness about existing end-of-life options and the importance of creating private legal directives. *Fence-sitters* argue that we should stop using "battle rhetoric" that characterizes natural death from an illness as 'losing', pressuring patients to *either* 'fight' to prolong life indefinitely by artificial measures, *or* try to 'take control' and die suddenly by artificial measures (MAID) so as not to be a "loser" of their fight.

After the 2015 court decriminalized the assistance of suicide (this court framed as "negligent" in *Fence-sitting* Camp narratives insofar as its decision was "maddeningly vague" and failed to draw clear lines about the intended scope of permitted activities), *Fence-sitters* argue that politicians should step up and craft a replacement law that regulates the assistance of suicide, as the more responsible choice over allowing legal limbo. Whatever that eventual replacement law looks like, *Fence-sitters* propose that elected officials should both move as quickly as possible in creating and enacting it, and take whatever time is necessary to construct an appropriately thoughtful law, ideally incorporating public feedback and data from foreign precedent, with care taken to ensure the law is clear about who may kill and under what precise circumstances. *Fence-sitters* argue that the law should be modest and not go as far as the furthest-reaching people want, and that MAID, as direct killing, is so high-stakes and distinct from other kinds of choices that the state should never extend it to minors, except on a "case by case" basis by court review. Strong safeguards and oversight are framed by *Fence-sitters* as a necessary accompaniment to legal MAID, with specific safeguards advocated such as mandatory psychiatric assessments, screening for undue influence, and informed consent. *Fence-sitters* praise government as having so far been wise to create a "high hurdle to obtaining a state-sanctioned, assisted death", and so far seeming reasonably cautious in seeking a balance between enabling MAID for those who want it, while seeking to protect the vulnerable from abuse, and protect the right of health workers to conscientiously object. However, at least one government committee's report is framed in *Fence-sitting* Camp narratives as villainously reproduced the false idea that forced referrals are necessary to ensure access (this report having failed to mention the proposed central information hub that had been agreed upon by both ‘sides’ as a mechanism for bypassing the need for referral).

Health workers are framed by *Fence-sitters* as heroic in their default role as caregivers, and as victimized when forced into a nerve-wracking, burdensome “ethical quagmire” of navigating a newly MAID-legal environment that they didn’t necessarily sign up for and haven’t been adequately trained for or guided through. In *Fence-sitting* narratives, technical issues frustrating doctors include “excessive paperwork” and “lack of good data collection”, and professional issues (apart from concern about pressures to participate against conscience) include the implicit accusation of ‘negligence’ against Quebecois ER doctors who, seemingly confused by MAID legalization, started failing to resuscitate solo suicide victims in the ER instead of resuscitating those patients (as obligatory by ongoing professional medical standards) for psychiatric treatment.

Fence-sitters advocate that systematic deficiencies in Canadian healthcare must be rectified, particularly critiquing the systematic stigma that deprioritizes mental healthcare, and the inadequacy of palliative training, funding, pain strategy, and access, which *Fence-sitters* argue have resulted in the problematic situation of Canadians being told they have a “right to die” *before* being told they have a “right to palliative care.” *Fence-sitters* also argue that poverty and unhealthy lifestyles that contribute to unhealthy aging must be addressed, and that we must somehow rectify the unsustainable situation of family and community disconnection in Canada, with over-reliance on the healthcare system and few isolated natural caregivers left. By whatever method, *Fence-sitters* emphasize that patients need to *somehow* have their fears addressed: fears of pain, fears of loneliness, fears of being a burden.

Chapter 8: Discussion and Conclusion

I will concentrate here on four key areas for discussion: (1) changes to the discourse across time, (2) the relative frequencies of narrative camp representation across media articles sampled, (3) comparisons between the three camps' most prominent characterization strategies, and (4) the relationship between post-2016 story morals and actual post-2016 policy developments in Canada. Finally, I will propose areas for future research.

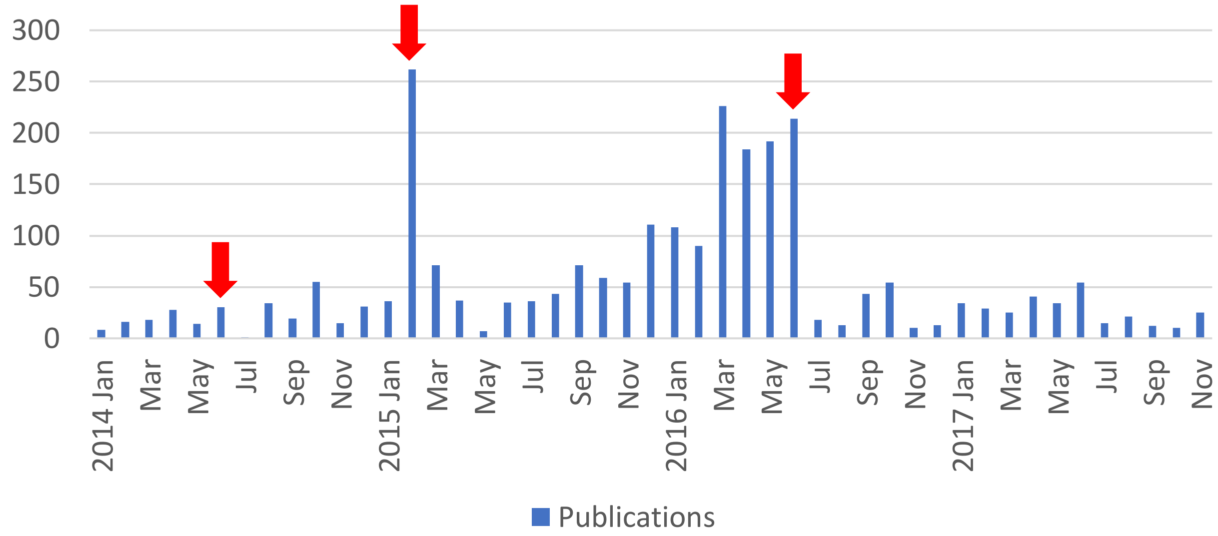
1) Changes to the Discourse Across Time

Regarding changes observable in the discourse across the decade reviewed, a few trends stand out as prominent. The first is that while there had been occasional 'blips' of media conversation on the topic of MAID going back decades, the overall volume of media articles published on the topic could generally be observed to increase from the moment an authority of some kind expressed the intent to possibly change public policy. The media debate would then drop off immediately after public officials announced the outcome of their deliberations, rising again only as new committees were formed and new legal/policy changes were specifically considered.

The timing of the increases and then abrupt decreases in volume of topical media articles (see Figure 3) suggests that this public debate was not just an already-occurring ideological venting of competing ideas, but rather a pragmatic and strategic political effort to engage with policy-makers. Whereas voices and narratives were amplified during periods when policy makers were known to be considering real change, a corresponding drop-off in debate participation followed policy outcome announcements, seeming to indicate general acceptance of those outcomes. (At least in the sense of accepting the idea that opportunities for influence are time-constrained.) This interpretation presumes that 'lacking acceptance of an outcome' would manifest as ongoing media story morals advocating for new outcomes. See 'Post-2016 Story Morals,' p. 151, for examples of such ongoing advocacy reflecting ongoing dissatisfaction with the new status quo (though lower in publishing frequency).

Figure 3

Overall Volume of Articles Published between January 2014 and November 2017



Note. This figure shows the overall volume of articles published across the time period of three main benchmark moments, based on original ProQuest data prior to reduction to a random sample. The date range for this figure exludes earliest/latest data to focus on benchmark moments. The three benchmarks indicated by arrows here represent: (1) June 5th 2014, Quebec provincially legalized MAID via Bill 52; (2) February 6th 2015, the federal prohibition against assisting suicide was struck from the Criminal Code via *Carter v Canada*; and (3) the amended law took effect 16 months later on June 17th 2016, after having been debated.

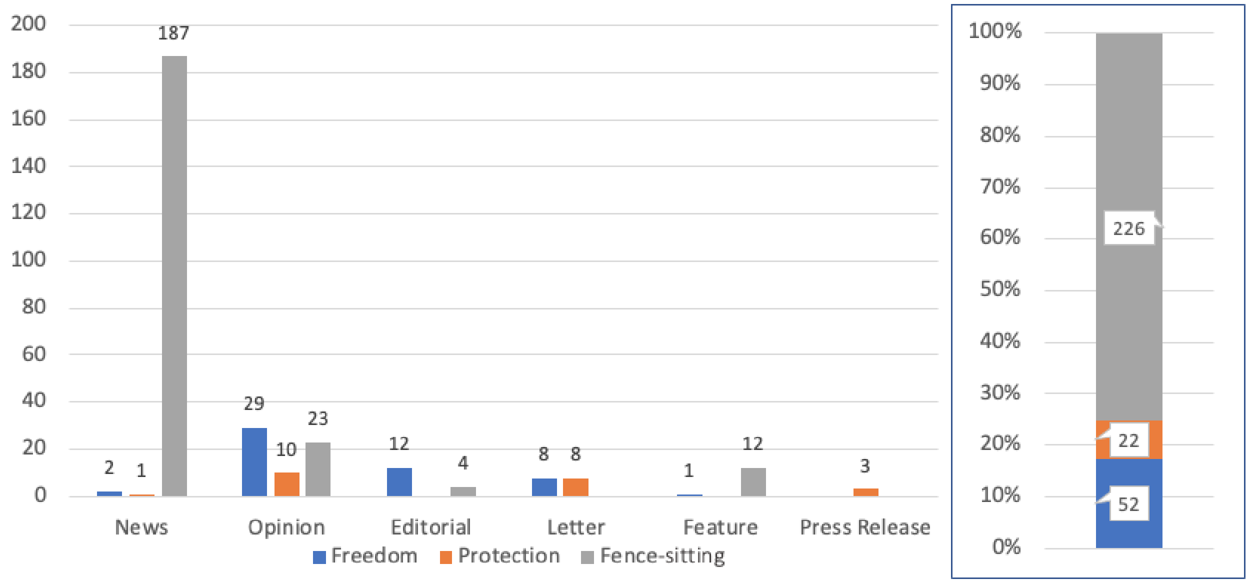
Particularly apparent in Figure 3 are the high volume of articles published when lawmakers were deciding the particulars of replacement law – that is, the law that would regulate MAID, replacing the legal gap left after decriminalization of suicide assistance. The question of whose political effort and whose acceptance of policy outcomes was reflected is beyond the scope of this research. It may be that average Canadian residents are widely inclined to participate in grassroots political activity, including by seeking out journalistic gatekeepers to make their voices heard in public media, and then – generally trusting institutionalized authority structures – accept authority-announced policy outcomes and lose interest in further debate. It alternately seems possible that a small number of organizationally affiliated activists (e.g. staff of Dying with Dignity Canada, whose voices were highlighted frequently in media narratives) played a large role in shaping the public discourse on this topic, including by prompting media gatekeepers to amplify their messages at particular times. Finally, given the potential gatekeeping influence of editorial boards – as discussed in the next subsection – it seems plausible that both voice-amplification prior to policy decisions, and then relative silence subsequent to single-camp-satisfactory policy outcomes, may be related to the policy preferences of editorial boards. Since the benchmark policy moments in question each resolved in favour of the policy narrative preferred by editorial boards, it is unclear whether publication-volume patterns would have differed if a benchmark policy moment had resolved in a direction less consistent with board preferences. Ultimately, the question of who played what role in an apparent pragmatic effort to influence policy makers – and the extent to which the drop-off in topical publication indicated acceptance of public policy and if so, of what kind and by whom – is one for future research. I anticipate that any answer may be mixed. That is, that topical publication volume reflected policy-change effort and policy-outcome acceptance by at least some citizens, activists, and journalist gatekeepers, if not necessarily by all in these groups, and if not equally impacted by each.

2) Frequency Differences: Narrative Camp Representation

Byline authors typically avoided explicitly self-identifying as advocates for either the *Freedom* or *Protection* positions, though those who declared a stance were more than twice as likely to self-identify as *Freedom* advocates than as *Protection* advocates; see Figure 4, next page. At the same time, narrative choices about whom to interview, which voices and arguments to highlight and which voices and arguments to leave invisible – or only critiqued – effectively produced a *Freedom* and/or *Protection* narrative more often than a *Fence-sitting* narrative. While each article could theoretically contain elements from all three narrative camps, equal representation of all three stories per article was not the trend (with only 432 stories told across 300 media articles), and *Freedom* story elements were more frequently published (by a considerable margin) than *Protection* story elements, which were more frequently published (by a smaller margin) than *Fence-sitting* story elements. See Figure 5, next page.

Figure 4

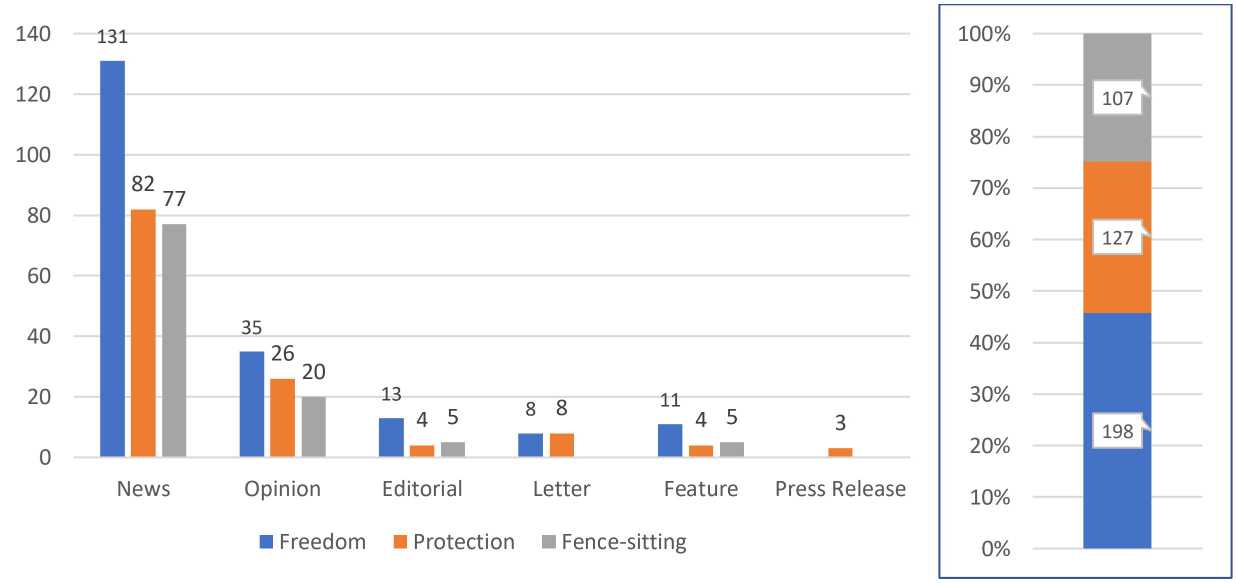
Explicit Self-identification as Camp Advocate by Byline Authors in the Random Sample



Note. This figure shows the number of media articles (divided by sub-genre) in which the byline author explicitly self-identified as an advocate for one of the three narrative camps. A byline author's advocacy stance was coded as *Fence-sitting* if they did not use their authorial voice to explicitly advocate for either the *Freedom* or *Protection* policy positions.

Figure 5

Media Articles Containing Camp-Specific Narrative Content in the Random Sample



Note. This figure shows the number of media articles, divided by sub-genre, containing at least one story moral and/or one piece of characterization framed according to the associated narrative camp. Here, 'Letter' stands for 'Letter to the Editor.'

The sample was clearly dominated by articles in the 'news' sub-genre, and the news sub-genre was dominated by journalist authors who, consistent with the journalistic norms of the news sub-genre, typically avoided using "I" language or otherwise *explicitly* editorializing about MAID. At the same time, the narrative choices made by byline authors, including in the news sub-genre, clearly tilted the frequency of narrative elements towards a *Freedom*-dominant storyline in the publication outcome. Of particular interest I note the byline advocacy and content trends of the editorial sub-genre. Few editorials adopted *Fence-sitting* positionality about MAID and zero editorials expressed *Protection* advocacy. In contrast, most editorials explicitly advocated for the *Freedom* position with opinion-self-identifying statements. For example (emphases added):

> "We believe it's time for government to open up a full, comprehensive and meaningful discussion on the issue, working towards changes in legislation that uphold… the right of an individual, faced with the suffering brought on by a terminal illness, to choose to die with dignity." (Prince George Citizen, Editorial, Sept 2013)

While editorials themselves constituted a very small number of overall articles published and sampled, the ratios of narrative camp content (*Freedom:Protection:Fence-sitting*) seemed strikingly similar between editorials and other article sub-genres, with a strong preference for publishing *Freedom*-framed narrative content. This was especially true in the Feature subgenre, which included camp-specific narrative elements in nearly identical ratio to editorials, with the key difference being that while editorials acknowledged *Freedom* advocacy in their authorial voice, Feature authors typically avoided overt advocacy. Instead, they used other techniques, such as primarily interviewing *Freedom* characters, or omitting mention of *Protection* perspectives, to achieve the same messaging effect.

The main exception to this apparent correlation between editorials and other subgenres seemed to be in the Letter to the Editor subsection. I hypothesize that this may be due to a subgenre normative standard aimed towards a particular vision of 'balance' and 'printing both sides'. The Press Release subgenre similarly seemed to deviate from the larger trend, but here my interpretive scheme may be responsible.[20] For now then, I set aside the Letter to the Editor sub-genre, and the Press Release sub-genre whose categorization as such may be debateable. The remaining correlation between views expressed by editorial boards, and the content of other articles published by those outlets, seems worthy of future exploration into editorial board gatekeeping impact on discourse about contentious social issues. One further piece of supporting evidence drawn from the data, suggesting that editors may play a role in influencing journalistic direction and published content, seemed indicated by the introduction to one Feature-genre story in particular (emphases mine):

> “About three years ago, a senior editor some two decades my junior invited me into his office, a ramshackle enclave dubbed "the sunshine room" because the walls were painted a noxious shade of yellow. After tapping on his BlackBerry for several minutes while I computed my potential severance package versus my outstanding mortgage payments, he pulled his gaze away from his screen, peered at me quizzically and announced my new assignment: Find somebody who wants to die and write about it for the paper. "Do you have the stomach for such a story?" he asked. "Of course I do," I retorted with my customary defiance, eyes flashing at the notion that I might not have the same byline hunger as a young hire fresh out of J-school.” (The Globe and Mail, Feature, Apr 2016)

This Feature story journalist’s description of receiving her assignment could go some way to explaining the conformity of feature subgenre content to editorial subgenre content: an unequal power dynamic and atmosphere of perceived risk in which a journalist may be incentivized to try to please her editor in order to retain her job. Her feature story of 2,729 words ultimately included zero *Protection*

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[20] In ProQuest, two of these three articles were identified as belonging to the ‘News’ sub-genre, and one was identified as belonging to the Opinion sub-genre. However, the content seemed, to me, composed by an organization and then published as-is by the media outlet. The three articles included two copies of a letter in which the CEO of a disability advocacy organization referenced her organization’s concerns while using “we” language, and one printed excerpt from a presentation to a parliamentary committee by a representative of a faith-based healthcare coalition, also using ‘we’ language. Certain *Freedom*-penned content could also, arguably, have been categorizable as press release (such as letters written by organizational leaders of Dying with Dignity), but since those letters seemed more casual of style and used “I” language, I interpreted them as most closely aligned with a standard Opinion piece and left them in their original ‘Opinion’ sub-genre as identified by ProQuest.

or *Fence-sitting* narrative elements. Instead, it promoted *Freedom* narrative elements both through the expressed views of those persons interviewed (and through the atmospherically warm and sympathetic framing of *Freedom* characters discussed), and through the editorializing comments of the journalist, who argued in her own words for the provision of "peaceful exits" (MAID) for minors, dementia patients with advance directives, and those with "refractory depression."

In sum, frequency patterns of narrative camp representation across subgenres, supported by emergent qualitative descriptions of editor-assigned work, suggest a possible correlation between editorial board viewpoints and media content subsequently published, that I propose would be a fruitful area for future research.

3) Comparison between the Three Camps' Framing of Character

All three camps – *Freedom, Protection,* and *Fence-sitting* – tell stories in which victims, villains, and heroes engage the sympathies of the reader. Each of the camps employ Victim characters more frequently than Villain characters, and Villain characters more frequently than Hero characters. This victim-centrality, along with the highlighting of villains more frequently than heroes who might come to the rescue, seems structured to impart a sense of urgency and obligation, encouraging readers to respond to the victim's plight by supporting an underdog-hero's battle against a looming overdog-villain. And for all three camps, more than 50% of victims were framed as falling into the same category: the 'patient' who is the prospective MAID recipient.

At this point, however, differences emerge. First, each camp framed the 'patient' victim group as victimized for different reasons: *Freedom* narratives emphasized the victimhood of suffering, *Protection* narratives emphasized the victimhood of vulnerability, and *Fence-sitting* narratives emphasized both. Next, the *Freedom* patient victim accounted for 72% of the *Freedom* victim cast: almost three quarters of their victim cast, presenting a remarkably singular, uncomplicated victim-message to the reader. In contrast, the patient-victim accounted for only 54% of the *Protection* victim cast and 57% of the *Fence-sitting* cast, with these narratives identifying other groups as prominent victims, especially health workers and the public. This resulted in slightly more complicated victim-messages, potentially less resonant with a casual reader. The *Freedom* cast was also notable for having the most diverse Villain cast, with 14 separate villain subcategories (ahead of *Protection*'s 12, and *Fence-sitting*'s nine). The *Fence-sitting* cast particularly stood out for its simplified Hero cast (with only four categories of hero, compared to *Protection*'s eight and *Freedom's* 11). And the *Protection* camp particularly stood out for a peculiar quality of its Villain cast: a priority emphasis on abstract and impersonal villains (such as discourse and dry legal statute) rather than on personal villains (such as politicians or judges) who might hypothetically feel social pressure from being narratively framed as villains.

Both the *Freedom* narrative and the *Fence-sitting* narrative characterized their primary villain and primary hero as the representatives of state power. For the Freedom camp particularly this choice of villain/hero resonates, given its power both to veto court rulings via the 'Notwithstanding' clause and to write new laws. I came to call this emergent narrative phenomenon the 'carrot-and-stick' technique: that is, promising to paint a character as heroic (desirable social status) for making one choice, while threatening to paint them as villainous (unpleasant social status) for making a different choice. For *Freedom* advocates*,* government figures were framed as the top 25% of heroes and top 19% of villains; for *Fence-sitters,* government figures were framed as the top 39% of heroes and top 29% of villains.

In contrast, *Protection* narratives mixed and matched their most frequently discussed heroes and villains, with the top two *Protection* heroes being the General Public (26%) and Health Workers (18%), and the top two *Protection* villains being Discourse (22%) and Law/Policy (18%). *Protectors* prominently heroized person groups such as the general public and health workers, but avoided prioritizing villainization of person groups. Instead they prioritized vilifying abstract concepts or impersonal phenomena (such as discourse and law), which cannot, of course, 'feel pressure' to change.

I hypothesize that perhaps prominent media vilification of politicians by *Freedom* advocates, while simultaneously promising politicians hero status for *Freedom*-aligning action, contributed to the stronger political success of *Freedom* policy goals. The reason for the *Protection* narrative's relative avoidance of this primary – and seemingly pragmatic – characterization strategy adopted by both other camps is not immediately obvious and may suggest a fruitful area for further exploration.

One final observation regards characterization differences pertaining to the heroization language used in *Protection* narratives. *Protection* narratives seemed relatively weak when it came to using heroizing language. This was particularly noticeable in the category of health worker heroes: While *Protection*-framed health worker heroes constituted 18% of the *Protection* hero cast, examples regularly met the minimum coding criteria for 'hero' framing (see pre-set criteria for applying codes, p. 42), rather than exceeding it. This often looked like framing a health worker as "promoting a good" from the *Protection* perspective (e.g. Dr. Saba pursuing a court case to achieve *Protection* goals), without the addition of extensive praise words for this health worker. In contrast, *Freedom* narratives were typically extensive in their praise words for physicians perceived to align with *Freedom*-consistent beliefs or activities, describing such doctors as courageous, supportive, expert, trustworthy, compassionate, angelic, and so on. Whereas *Protection* physician heroization was often worded briefly, in the space of a single line or two, *Freedom* physician heroization often included paragraphs of supplemental description, with the physician framed as carefully listening to a patient and helping them feel heard; amiably accompanying them to their home; watching the patient respond positively to what the physician says and does; and so on. *Freedom* narratives extensively gave atmospheric descriptions of health workers helping people to die by MAID, with descriptions of smiles, warm embraces, and comforting conversation. *Protection* narratives, however, rarely gave atmospheric descriptions of health workers helping people to die without MAID in comfortable palliative circumstances. When a *Protection* physician was described as "compassionate", it was typically briefly and defensively framed, in reaction against the accusation that if they do not assist in MAID then they must not be compassionate. Proactive *Protection Camp* heroization of health workers, unapologetically or extensively praising a health worker for adhering to *Protection*-specific values or practices, was rare.

Ultimately, *Freedom* narratives vilified MAID-objecting physicians in more than twice as many media articles as *Protection* narratives heroized MAID-objecting physicians, and *Protection* heroization of physicians was weakly worded when it occurred. I hypothesize from this that a media-aware health worker may have felt similar public-image pressures as a politician to conform to the vision of their practice articulated by *Freedom* narratives rather than the vision articulated by *Protection* narratives.

4) Post-2016 Story Morals

Three key calls to action were promoted/debated after baseline MAID legalization, identifiable by tracking code category recurrence within a certain time period and then investigating the qualitative content associated with those code categories in the time period. To keep the discussion narrowly focused, I chose to examine here only those story morals that registered at least one 'spike' in activity after June 2016 (defining 'spike' as 2+ associated articles within one month within the random sample) or, in one case, occurred no more than once per month, but recurred consistently until the cessation of data collection. See Table 1 (next page) for summaries of the most prominent eight post-2016 story morals which I then break down into three basic areas of ongoing debate and calls to action.

Table 1

Story Morals Most Active in the Random Sample after June 2016

	After June 2016, Something should (still) be done about…	Specifically/mostly…
Freedom Camp	*Baseline Legality	*Retroactive affirmation that baseline legality (now achieved) was the right step.*
	*MAID Access Categories	Access should be expanded; especially to those whose death is not "reasonably foreseeable," those who signed advance directives before losing competency (i.e. dementia patients), minors, and the mentally ill.
	*Conscientious Objection	Conscientious objection rights should be restricted; institution-level objection should be forbidden, and health workers should be obligated to at least refer for MAID.
	*Money/Resources	Public funding should be stripped from care sites that prohibit MAID on their premises. (Also: charity should be redirected to MAID-affirming organizations. Compensation for MAID performers should increase.)
Protection Camp	*Baseline Legality	Suicide assistance should be recriminalized.
	*MAID Access Categories	Access should be restricted; especially never expanded to minors, the mentally ill, or those who can't competently consent at the time.
	**Conscientious Objection	Conscientious objection rights should be firmly protected, including protection from pressure to participate in referral for MAID.
Fence-sitting Camp	*Health System	Improve quality/access of palliative care, mental healthcare, and pain management.

Note. This table includes only the highest frequency story morals still active after June 2016.
* At least two articles included a story moral from this subcategory within the same month (in at least one month) after June 2016.
** This story moral appeared no more than once per month after June 2016, but occurred in five separate months at similar intervals up until the cessation of data collection.

For the purpose of this section, I discard the baseline debate between *Protection* and *Freedom* narrators about whether or not MAID should have been legalized (it clearly has been legalized, and was not recriminalized; no further space need be spent examining post-2016 outcomes on that front). I further merge the *Freedom* story morals about conscientious objection and money/resources (discarding infrequent 'money' morals like increasing compensation for MAID providers), identifying as a common thread the argument that objecting institutions should lose funding. This leaves us with three main story morals promoted/debated post-2016: Access category limitation/expansion; systematic improvements to institutional healthcare; and conscientious objection rights.

I hypothesized that these areas of continued discourse – representing areas of continued manifest dissatisfaction with even the new status quo – could potentially be used to predict felt-pressures upon policy makers toward new policy actions. Assuming that policy makers respond to felt-pressures imposed by public media discourse (or behind-the-scenes pressures of other sorts that are reflected in public media discourse), I hypothesized that these post-2016 media story morals might predict new political developments in Canada. I also hypothesized that political developments in the *Fence-sitting* story moral area of systematic healthcare improvement might be expected to be weakest or least likely, given that this story moral (despite a frequency 'spike') gave an appearance of petering out (last appearing February 2017, over a year prior to the end of data collection), and may not have persisted. It may be that *Fence-sitters* considered the issue settled by legalization and moved on, whereas the polarized *Freedom* and *Protection* narrators remained interested in the ongoing MAID debate.

Helpfully, given that this Discussion is now being finalized five years after 2016, we can look back from 2021 to investigate whether there is indeed evidence of political development in the three areas that seemed predicted by post-2016 story moral data.

a) Category Limitation or Expansion

> A. Holierhoek says that there is "a law in place that describes exactly how, when, and under which circumstances MAiD can be given" which prevents having to fear it. But if he thinks back to before June 17, 2016 that law was not on the books. So just as easily as his statement became true with the stroke of a pen, that statement can be changed with a stroke of a pen... When C-14 became law in June 2016, there were already critics of it that claimed it was too restrictive, so you can be sure there are groups that are lobbying to change that law that A. Holierhoek puts his faith in. (The Chilliwack Progress, Letter, Mar 2018)

As alluded to by apprehensive *Protection* narratives, the findings of this research showed that *Freedom* arguments to expand parameters of access to MAID began appearing in Canadian media articles within a few days of the baseline decriminalization of suicide assistance. *Freedom* narratives largely shifted across time from a strategic narrative tone of reassurance about the proposed limitations of MAID law, to a strategic narrative tone of urgent expansionism. This typically involved framing category limitations as "discrimination" against those groups "excluded" from "access" to MAID (a procedure narratively framed as integral to a 'right to die' now argued by *Freedom* advocates to be reflected in law). This expansionist development is consistent with literature review predictions: Chilton (2014), for example, observed that public support for expansionism of new "rights" accelerates in the presence of a formally defined legal obligation. Given that Canada now seems to recognize a 'right to die' (as phrased in public discourse, if not in legal documents), we would expect according to Chilton's theory to see public dissent against MAID decline, and to see support for the *Freedom* position, including its expansionist elements, increase. This would also be consistent with the prediction of Kemmelmeier et al. (2002) that any country which legalizes euthanasia for the specific reason of adhering to 'individualist autonomy' values will soon face pressure to expand euthanasia access to those experiencing a variety of subjective sufferings.

Freedom narratives especially argued that access categories should be expanded to (1) those for whom death is not otherwise "reasonably foreseeable"; (2) persons who have lost cognitive capacity to consent but previously signed advance directives authorizing MAID; (3) minors; and (4) the mentally ill. Interestingly, these categories reflect the pre-war preferences of 1930s members of the Euthanasia Society of America.[21] This seems to show that these proposed areas of expansion are not 'new' additions to the euthanasia conversation; they are not afterthoughts that emerged only after legal change in Canada (except perhaps in the minds of individual contributors to the contemporary conversation). Rather, promotion of euthanasia for non-terminal, non-adult, and non-cognitively-competent persons pre-dates the contemporary Canadian conversation by a century. Under this broader historical view of the conversation, MAID for terminally ill and cognitively competent adults seems to have functioned as a "wedge" issue, later used to leverage a more expansive scope for MAID, advocacy for which nonetheless pre-dated this "wedge" level of legalization.

Actual outcomes in Canada so far regarding access categories

Consistent with the post-2016 preferences of *Freedom* media narratives, the requirement that MAID be reserved for those for whom death is already "reasonably foreseeable" (established in the 2016 version of the law) was removed from the 2021 update of the law (Government of Canada, 2021). While formal Advance Directives remain an ongoing matter of deliberation, changes to the final consent requirement were also made. This allows for the waiving of final consent for those for

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[21] In the 1930s, the high rate of American suicides during the Great Depression (including suicides of public figures) was followed by increasingly organized and formal support for euthanasia, with groups such as the Euthanasia Society of America (ESA) forming to promote their message and lobby for legalization. Some ESA members argued that euthanasia legalization should ultimately extend to the "unconscious elderly, the incurably insane, and disabled infants and children", compromising on final proposals of legislation limited to competent adults only in the hopes that at least such limited legislation might pass (Chang, 2018, pp. 184-185). However, not only did this compromise legislation not pass at the time – a lobbying failure attributed to lack of political support due to "vocal religious opposition" (Chang, 2018, p. 185) – but the forthcoming Nazi crimes of World War II soon turned public opinion against euthanasia for decades to come. It wasn't until the 1960s that euthanasia advocates began to reintroduce their cause, rebranded this time after the model of successful 'civil rights' campaigns of the era, as just one more matter of "freedom of choice" (Chang, 2018, pp. 188-189).

whom death is reasonably foreseeable and who lose capacity between the initial approval of their request and the actual date of the MAID event – unless they then demonstrate, "by words, sounds or gestures, refusal to have the substance administered or resistance to its administration" (Government of Canada, 2021). The 2021 update of the law also reflected the *Freedom Camp* preference that MAID become legal for persons whose sole condition is mental illness. On this, a little more must be said.

Despite the disproportionate ratio of *Freedom:Protection* narrative elements in general, an equal absolute number of media articles from both camps expressed story morals related to mental illness as a MAID access category. In the random sample, 11 *Freedom* narratives advocated to expand MAID to the mentally ill, and 11 *Protection* narratives advocated against this. This equal frequency of voice representation stands out against the backdrop of otherwise unequal voice representation, arguably indicating the high priority, for the *Protection Camp,* of advocating against MAID for the mentally ill.

Nonetheless, in the political sphere beyond public discourse, a parliamentary committee ultimately advocated for the *Freedom* position, and the 2021 legal update has enshrined this area of expansion into law, albeit with a time delay for implementation. Mental illness will automatically become a MAID-qualifying condition in Canada on March 17, 2023 (absent intervening circumstances). This time delay is indicated to intend time for an "independent review" by experts tasked with recommending the "protocols, guidance and safeguards" meant to accompany this expansion (Bill C-7, 2021). Finally, Bill C-7 also called for a "comprehensive review" to be "undertaken by a Joint Committee of both Houses of Parliament" regarding possible expansion to other *Freedom*-proposed categories such as "mature minors" and "advance requests." Finally, this committee is to examine other relevant issues such as "the state of palliative care in Canada and the protection of Canadians with disabilities" (Bill C-7, 2021) – which leads us to the second post-2016 story moral.

b) Institutional Healthcare Improvements

In an uncontested story moral, *Fence-sitters* straightforwardly advocated through early 2017 for improvements to institutional healthcare in Canada, especially palliative and mental healthcare. As regards palliative care, there is moderate if inconclusive post-2016 policy action to report.

Actual outcomes in Canada so far regarding improvements to palliative care

In late 2017, Parliament called for the development of a Canadian palliative care framework. In December 2018, Health Canada published its Framework on Palliative Care in Canada, laying out goals, priorities, and measures for improving Canadian palliative care. These included recognizing the role of government in funding and administering relevant programs and healthcare services. The Framework was aspirational in nature, 'inviting' relevant parties to participate in implementing its findings, but lacking the authority to make binding commitments. It did, however, include mention of commitments previously made, such as Health Canada's commitment to establishing an Office of Palliative Care from existing funds to improve coordination of activities into the future. The trend of recommendations in the 2018 document focused on shifting palliative care activities to the realm of regularly practicing health teams or caregivers in a newly palliative *approach* to existing caregiving provided by non-specialists. The scope of specialized palliative care was recommended to take place in hospices for only a minority of cases involving "complex and persistent" needs (Health Canada, 2018, p. 23). Nonetheless, post-2016 economic investments were also mentioned in the appendices. These included: $6 billion committed federally across a ten-year period starting in 2017, to be shared between provinces and territories for the purpose of increasing availability of home and palliative care; $184.6 million across five years (also starting in 2017) set apart in the federal budget for investment in these same services for First Nations and Inuit communities; and $20 million dollars between 2018-2023 plus $4 million per year "for community-based projects to improve the wellbeing of people living with dementia" and their caregivers (Health Canada, 2018, p. 36).

These investments give reason to believe that the government is interested in increasing availability of MAID alternatives at the same time as increasing availability of MAID. At the same time, the CHPCA's most recent fact sheet (published in 2021) notes no new update since 2018 by which to assess whether actual access to palliative care has measurably improved. The most recent data available shows that while 66% of those who died in 2016-17 received some type of home care service in their last year of life, only 15% received publicly funded palliative home care in the provinces where this could be measured (Canadian Institution for Health Information, 2018, p. 14.) To further assess the state of Canadian palliative care improvement is beyond the scope of this research (and would duplicate work already assigned by Bill C-7 to the joint parliamentary committee). I note then only that the results of this "comprehensive review," meant to be currently or soon underway by the committee, will merit close attention.

The economic-pressure concerns raised by Titterington et al. (2013) and the risks illuminated by Hardt and Negri's analysis of capital relations (2009) suggest a need for ongoing monitoring of the potential impact of economic pressures on the shape of MAID policies. A particularly relevant metric for monitoring will be whether access to (potentially expensive) 'assisted living' alternatives increase at a commensurate rate with expansions of access to 'assisted dying' for more categories of person. (Especially monitoring whether the populations to whom 'assisted dying' is increasingly expanded are those for whom 'assisted living' care is particularly expensive or complicated.)

Finally, beyond the question of economic pressure potentially influencing policy development, it seems appropriate to continually monitor the risk of psycho-social influence upon patients who sense economic burden concerns (and biomedical personhood views) from their caregivers. The insights of Butler and Rose return to mind, alongside expressions of anxiety emergent from the Canadian media narratives here analyzed. Might interviews or ethnographic research across time reveal a patient population increasingly sensitive to a perceived narrative that expecting high quality palliative care or assisted living is expecting an undue "waste" of resources on their non-person self? Might vulnerable community members feel psycho-social pressure to avoid asking for care, because they sense that those they ask may consider their request to be "too much" – especially in an environment of increasingly easier access to MAID, if alternatives do not seem equally, realistically accessible?

MAID law as currently written in Canada requires only that a patient be informed of those suffering-relief alternatives to MAID which are actually "available" to them (Government of Canada, 2021). The availability of palliative care, counselling services, and other forms of suffering relief are unevenly distributed among the population. It therefore seems necessary to continually question the local reality of "available" alternatives, and the implications for what is meant to be the free and autonomous choice of a given individual (especially a precariously vulnerable individual) to live and die in a manner of their choosing. A goal of 'freedom' would seem to imply preserving and enlarging the freedom of all individuals to actualize the lifeways (and deathways) they desire: not only paving the way for those who desire lethal injection, but also paving the way for those who desire ongoing supported care.

c) Conscientious Objection

Finally, it is necessary to discuss the post-2016 continuation of media discourse debating conscientious objection rights – a particularly contentious struggle between *Freedom* and *Protection* story morals. It would seem illuminating to begin by demonstrating how the framing of Canada's media MAID conversation changed after baseline MAID legalization, particularly among *Freedom* narratives. (*Protection* narratives seemed relatively consistent – or non-adaptive – in content before and after legal change). *Freedom* narratives trended across time towards reframing the purpose and nature of MAID laws such that the suggested purposes of legal amendment prior and subsequent to baseline legalization were markedly different. Prior to the baseline decriminalization of suicide assistance, *Freedom* narratives frequently framed the goal of proposed legal amendment as being protection from prosecution for those who might wish to assist a patient in a direct + active life-ending action. That is, legal amendment was framed as necessary to legally safeguard third parties (including loved ones, but especially physicians) who wanted to 'opt in' to participation, free from the risk of criminal prosecution. Reassurances were often offered to the effect that physicians who did not choose to opt in would not be forced to participate.

> Quebec's Dying with Dignity commission recommended in March that rules be established to shelter from prosecution doctors who offer terminally-ill patients "medical assistance to die." (The Vancouver Sun, News, Feb 2012)
>
> Quebec is moving to challenge the federal law with proposed legislation that would protect from prosecution doctors who administer life-ending drugs to terminally ill patients experiencing unbearable physical or psychological suffering.… no doctor would be forced under the legislation to participate in "medical aid in dying" against his or her will… (The Gazette, News, Aug 2013)
>
> Physicians largely agree that their colleagues should not have to assist in a death if they have a conscientious objection… the Criminal Code provisions should be retained to prevent abuses or coerced consent, but with an exemption for provincially designated end-of-life clinics that would shield doctors and patients from prosecution. (Star – Phoenix, Opinion, Sept 2013)
>
> "Nothing in the court's decision forces doctors to assist in a suicide…" (Star – Phoenix, News, Feb 2015)

In contrast, after baseline decriminalization of MAID in 2015 and continuing past enactment of replacement legislation in 2016, *Freedom* narrative content substantially shifted. Now, legal amendment was framed as having been ordered towards ensuring that every individual who desires MAID can be guaranteed MAID, at a time and location most preferred by the individual, even at the cost of requiring the participation of conscientiously objecting physicians or institutions. Under the post-legalization *Freedom*-framed conceptualization of MAID as a "health care service" like any other, *Freedom* narratives increasingly used the conceptual-linguistic framing of 'MAID as healthcare' to argue that health workers should be obligatory participants by reason of their professional category. This new framing especially involved arguing for a 'minimum' participation requirement that all physicians provide "effective referrals" for MAID. Post-2016 *Freedom Camp* narratives framed physicians as not having a “right” to practice medicine according to their “own personal morals” when those morals conflict with a patient’s desire to access a procedure deemed legally permissible by the state.

In other words, legal amendment seems to have become reframed from a goal of protecting from prosecution those physicians who desired to ‘opt in’ to participation, to a goal of pressuring all physicians to participate (at least by effective referrals), regardless of a physician’s desire to ‘opt out.'

> “… the profession is shirking its responsibilities by not stepping up and clarifying that yes, we do need to suspend our own personal morals…” (Montreal Gazette, News, Feb 2015)
>
> “As a federal expert panel reviews the issues, polls show doctors are divided, with some "conscientious objectors" demanding the right to play no part whatsoever in helping patients end their lives. That's unreasonable, in our view.” (Star – Phoenix, Editorial, Aug 2015)
>
> Quebec Health Minister Gaetan Barrette… accused palliative-care doctors - who have a right under the law to conscientious objection - of acting like hospital owners rather than service providers. "The law was very much framed as being in a continuum, along the lines of (euthanasia) being the end part of palliative care, so it is a logistical problem if the significant majority of palliative-care professionals are saying we will invoke conscientious objection," said Dr. Eugene Bereza, director of the Centre for Applied Ethics at the McGill University Health Centre. (Toronto Star, News, Sept 2015)
>
> "… patient rights trump physician rights.” (The Globe and Mail, Opinion, Feb 2016)
>
> “Giving doctors a way out doesn’t help to keep Canadians free.” (The Spectator, Letter, Apr 2016)
>
> To me, it is also a medical sin for doctors to turn a blind eye to this request when it's their prescribed role to end terminal suffering. (Prince Albert Daily Herald, Opinion, Nov 2016)

In one last example, I offer the following excerpt from the larger original dataset of 2,999 articles. This quote from a national media article was not scooped up in the random sample, but seems noteworthy due to the institutional prestige (and therefore potentially disproportionate influence) of the narrator(s) involved, and due to the concrete specificity of their proposal. The bioethicists referenced in this excerpt were professors at Queen’s and Oxford universities respectively, and were also “editors of two major bioethics journals,” indicating the information-gatekeeping and policy-advisory roles they may be positioned to play beyond the realm of media discourse:

> Authorities should bar doctors from refusing services like abortion and assisted death on moral grounds, and screen out potential medical students who might impose their values on patients, leading Canadian and British bioethicists argue… They argue that physicians have no right to opt out of lawful medical services – from abortion to prescribing contraceptives – that are requested by a patient and in the person's interest. Those who let conscientious objection affect patient care are clearly unprofessional, say Udo Schuklenk and Julian Savulescu. "Doctors must put patients' interests ahead of their own integrity," they write in the journal Bioethics. "If this leads to feelings of guilty remorse or them dropping out of the profession, so be it," says the bluntly worded piece. "There is an oversupply of people wishing to be doctors. The place to debate issues of contraception, abortion and euthanasia is at the societal level, not the bedside." … They suggest doctors do not necessarily have to perform the service themselves, though they must at least ensure someone else provides it…. Schuklenk said it is debatable whether currently practising doctors should be barred from practicing because they morally object to facilitating certain legal services. But it would be reasonable to screen applicants to medical school and eliminate those unable to put aside their moral values, he said, comparing the idea to a medical faculty in South Africa rejecting racist students. Such screening might exclude people of certain religious beliefs from becoming doctors, but there is little evidence that would be detrimental to patients, the commentary says. (National Post, News, Sept 2016)

Taking these several excerpts altogether, we can see an abrupt and foundational reframing in *Freedom* narratives of what it means to be a health worker. The rhetorical framing of conscientiously objecting palliative care doctors as acting like "owners" of hospitals rather than "service providers" in them, seems to reflect Walter's observation (2012) of the rationalized bureaucratization of the healthcare profession since the Industrial Revolution. Health workers seem increasingly expected (at least by *Freedom* advocates) to operate as interchangeable, replaceable 'human resource' units in a larger bureaucratized machine, available to adjust their 'menu of services' according to the direction set by the "owners" of the institutions. The reigning virtue of this rationalized bureaucratic "service provider" physician seems to be, suggests bioethicist Schuklenk, 'professionalism.' And 'professionalism' seems defined by Schuklenk as putting "patients' interests" – as defined "at the societal level," i.e. ultimately by the state – "ahead of their own integrity."

This is a very different conceptual model of the medical profession than what came before. For contrast, consider medical ethicist T.A. Cavanaugh's account of the 'birth of the medical profession' (in the Western tradition). Circa 460 BC, a Greek physician from the island of Cos was born into the Asclepiad clan: descendants – so they said – of the demigod Asclepius, son of Apollo. The Asclepiads were, by birthright, 'Apollonian' physicians: possessors of a secret family art passed down between fathers and sons. The Apollonian physician's skillset could be used either for healing or for harming,[22] just as Apollo himself was both a healer and wilful spreader of disease, and Asclepius his son received from Medusa (and used) both vials of blood: the vial for healing and the vial for sickening. Then, everything changed: circa 434 BC, the Asclepiad Hippocrates revolutionized medicine for millennia to come. Suddenly extending beyond the realm of secret family art, Hippocrates trained unrelated males bound by an oath before the gods to practice their new art in accordance with ethically specific promises under self-invoked pain of death and dishonour. Promises of the 'Hippocratic Oath' included: avoiding sexual relations with members of a patient's household; strict silence and discretion regarding the private matters of others; never giving an abortifacient – and never giving anyone a deadly drug, even if asked, nor counselling towards use of a deadly drug. (Cavanaugh, 2018)[23]

Hippocrates' impact resonated throughout the Western world for millennia to come. Versions of his famous oath have been adjusted across time and place: for example, a Christian or Hindu oath-taker would not list Apollo as the sacred witness before whom their oath is sworn, nor would a contemporary oath-taker make the original cultural promise to materially support their teacher as

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[22] Cavanaugh (2018) further subdivides Apollonian medicine into (1) Apollonian medicine (ambivalent about whether its skillset is used to heal or injure) and (2) Asclepian medicine (as that which opposes injuring but "does not consider the killing of a patient always to be an injury to the patient" (2018, p. 75)). Cavanaugh suggests examples of the Apollonian physician type as including a poisoner who assists in state executions, or a physician who uses his skillset to aid the military in developing techniques of torture.

[23] The relevant lines of the original Hippocratic Oath, translated to English, read:

> I swear by Apollo physician and Asclepius and Hygeia and Panacea, and by both all the gods and all [the goddesses], making [them my] witnesses… Regimens I will use for the benefit of the sick according to my ability and judgment, but [what is used] for harm and injustice I will keep away from [the sick]. I will neither give a deadly drug to anyone, though having been asked, nor will I lead the way to such counsel… But purely and piously I will watch over my life and my art… Now, to me making this oath fulfilled, and not breaking [it], may it be to share in life and art, being famous according to all men for all time; but [to me] transgressing and forswearing, the opposite of these. (Cavanaugh, 2018, pp. 151-155)

"equal to" their parents. There are other distinctions as well. However, the Hippocratic Oath has remained in use as a 'foundation' for medical oaths for 2,500 years, and public perception of medicine as a Hippocratic Oath-bound profession has endured. That is, as a profession bound by ethically specific oaths intended to be sacred (typically made before a supernatural witness), rather than as a profession bound to the changing ethical norms of a nation-state. Hippocrates' name recurred in the 21st century dataset of media articles, especially throughout *Protection Camp* narratives, which particularly identified with the prohibition against killing in the oath's original version:

> "The classic words of the Hippocratic Oath bind medical practitioners to keep patients 'from harm and injustice' and not to 'give a deadly drug to anybody who asked for it' nor to 'make a suggestion to this effect,' … The court's ruling not only erodes society's appreciation for human life," Durocher writes, "but also the trust and confidence all people, particularly those most vulnerable, should have in medical personnel and health-care institutions to protect their lives." (Montreal Gazette, News, June 2015)
>
> This is a sad period in history when the Supreme Court of Canada, in essence, will allow and perhaps mandate doctors to violate their Hippocratic oath and kill another human being even though there clearly are other options for dying with dignity. (The Windsor Star, Letter, Feb 2016)

As seen here, *Protectors* typically reference medicine as an oath-bound profession trustworthy due to its commitment to the protection of life, specifically including an oath not to kill (not to give or lead to counsel of a deadly drug). In contrast, when *Freedom* advocates addressed the legacy of Hippocrates, it was either to suggest rejecting the Hippocratic tradition of medicine entirely (a narrative thread from the larger dataset), or to focus only on the oath's line about not doing "harm." Having first suggested that the only Hippocratic constraint is not to harm, the *Freedom* advocate would then typically argue that health workers should be persuaded that killing is not always harm, or would argue that another guiding principle, such as to "comfort always," should take primacy.

> Opponents of physician-assisted suicide often quote part of the Hippocratic oath that guides doctors to "do no harm," but Drake points out the oath also calls on them to "comfort always." It is advice those providing palliative care should embrace, "rather than denying it and fighting against it," he said. (The Windsor Star, News, Mar 2016)

Incidentally, while it is possible that some local variant of a contemporary medical oath includes a promise to "comfort always" (as the *Freedom* advocate in the above media excerpt suggests), I have not found an example. Rather, the phrase, "To cure sometimes, to relieve often, and to comfort always," is described by Pract (2009) as a teaching aphorism possibly emergent from a "15th century folk saying" (Pract, 2009, para 15). And ultimately, even if incorporated into a medical oath, the interpretation of <u>active + direct</u> euthanasia as potentially non-harmful "comfort" would belong to what Cavanaugh calls the Asclepian (subset of Apollonian) view of medicine, not the Hippocratic view.

In other words, analyzing *Freedom* narratives through the lens of medical ethicist Cavanaugh, we observe that *Freedom* narratives seem to have rhetorically reframed the conceptual category of the 'medical profession' from its then-revolutionary Hippocratic origins 2,500 years ago, to pre-Hippocratic Apollonian norms (or to something else entirely). Insofar as rhetoric about conscientious objection, then, the *Freedom Camp* narrative seems incompatible with the Hippocratic interpretation of medical practice. *Freedom* advocates such as Schuklenk seem to acknowledge that those attached to the Hippocratic tradition, particularly religious persons who share Hippocrates' commitment to avoiding participation in the taking human life, may become excluded from the practice of medicine under the rationalized bureaucratic policy norms *Freedom* advocates propose. However, seeming to frame health workers primarily as human resources of which there is an "oversupply," Schuklenk concludes that such an exclusionary policy would not be "detrimental" to the outcome he desires. This outcome, it seems, is a McDonaldized model of health work in which care sites uniformly provide the same menu of services, and medically trained "service providers" can be interchangeably, rationally organized for maximal efficiency in delivering those services.

Crucially, *Freedom* advocates seem to set the McDonaldized expectation that a patient in Canada should, by default, expect to receive referral for MAID from any health worker they approach. That is, they do not frame health workers who refer for MAID as heroes who improve the status quo by increasing, from zero, the number of physicians from whom a patient can receive direct referral. Rather, they frame conscientiously objecting health workers as actively problematic villains, interfering with the smooth running of a health system in which the default number of physicians who refer for MAID is "all of them." The rhetorical setting of this expectation seems foundational to what I propose constitutes the *Freedom* narrative's participation in the "hero-protector narrative" model described by Clément, Lindemann and Sangar (2017).

This conceptual model is used, Clément et al. explain, to politically manufacture emotional consent of the public for the use of force against a villain framed to be an unjust aggressor. Under this model, a narrator seeks to activate both compassion (for a weak suffering victim) and moral anger (to elicit support for the use of force against a person-group framed as unjust or vicious). The second emotion is, Clément et al. argue, a necessary accompaniment to the first, so the audience will specifically support the use of force against the framed enemy rather than just supporting an alternate method of helping the suffering victim. I suggest that in this case, the use of 'force' proposed would be the use of political force to strip a health worker of her legally protected right to conscientious objection, forcibly alienating her from her labour by preventing her from practicing her profession in accordance with her conscience. (This proposed use of force stands in contrast to an alternative proposal for helping the suffering victim, identified by the CMA in *Fence-sitting* narratives: a central information hub that bypasses the need for physician referral.)[24] The framing of conscientious objectors as unjust ("perverse") aggressors is accomplished both by reframing passive abstention from a practice into active imposition of an experience, and by meeting Clément et al.'s criterion of attributing animalistic qualities to these 'villainous' objectors. Animalistic or perverse qualities

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[24] For example, see Findings, p. 127.

narratively attributed to conscientious objectors by *Freedom* advocates ranged from those suggesting generic sub-human traits like irrationality and incomprehensible "cruelty," to religious language denoting viciousness (e.g. "medical sin").

Finally, *Freedom* narratives argued that institution-level conscientious objection should be forbidden, and all care sites should be required to permit MAID on-site, with public funding stripped from hospitals or hospices that instead transfer MAID-seekers to MAID-providing locations.

> Quebec Health Minister Gaetan Barrette, a doctor himself, says the refusal by the province's hospices to provide the procedure amounts to "administrative fundamentalism"… (Toronto Star, News, Sep 2015)
>
> Catholic hospitals and some non-Catholic facilities do not allow doctors or nurse practitioners to assist patients in dying… But tax dollars are provided for health care. Hospitals, therefore, have no right to refuse Medical Assistance in Dying. And if they continue to do so they should lose public funding… I believe it borders on criminality to move dying patients to another hospital for MAID. (Prince Albert Daily Herald, Opinion, Nov 2016)

The use of criminalizing language – beyond reinforcing the "unjust aggressor" framing of conscientious objection by adding state-legal language connoting viciousness – seems congruous with the Canadian context. Perhaps our publicly funded healthcare system (albeit intermixed with elements of private funding for particular institutions) reinforces a centralized-state-legal, rather than diverse-local-community, lens through which to view healthcare provision. In Canada's publicly-funded healthcare system, *Freedom* narrators seem to perceive the ultimate bureaucratic authority for determining policies of local institutions as not resting with each institution's "owners" in the most immediate sense. (For example, bureaucratic authority not resting with a Jewish care home's board of directors who set a policy forbidding on-site killing, consistent with Jewish religion).

Instead, and despite the fact that Canada's public funding of healthcare does not technically involve public ownership of the institutions that receive this funding, the state itself seemed perceived by *Freedom* narrators as the ultimate "owner" of any facility to which a portion of publicly taxed funds are directed. The state was thereby framed by *Freedom* narratives as having the right to overrule an individual hospital's board of directors if the state wished performed on-site a practice the directors wished prohibited on-site. An individual healthcare site's board of directors were framed by *Freedom* advocates as "administrative fundamentalists" if they wished to set policies for the institution under their immediate governance in a manner consistent with their pre-existing view of medicine which continued to exclude human-killing. In contrast, *Freedom* narratives did not seem to frame a politician as an "administrative fundamentalist" if that politician wished to overrule local institutions to set top-down policies for them (at least so long as that politician favoured *Freedom Camp* story morals).

In sum, then, the *Freedom Camp* narratively shifted across time from first arguing that legal/policy change was necessary to protect health workers who desired to opt-in to MAID, to later arguing that legal/policy change is necessary to remove protections from health workers who desire to opt-out of MAID. To strategically persuade their reader to agree, *Freedom* advocates: reframed passive non-participation in the newly legal MAID referral process as an active and cruel attempt to "force" a patient to live by the health worker's (irrelevant) morals; argued for an implicitly non-Hippocratic conceptualization of the medical profession; and rhetorically set rationally bureaucratized, McDonaldized expectations that care sites and health workers should interchangeably participate in providing a uniform menu of state-determined services.

The *Protection Camp* narrative*,* in contrast, implicitly resisted or rejected the McDonaldized idea of healthcare as a field that should become maximally "efficient" in providing a uniform menu of services across care sites, and rejected the argument that access to MAID is dependent upon involving every health worker or care site. *Protection* narratives tended to adopt a Hippocratic (rather than Apollonian) view of medicine, and appealed for lawmakers to protect diversity by protecting the rights of health workers to practice medicine according to conscience, including abstaining from participation by referral in the newly legal practice of MAID.

Actual outcomes in Canada so far regarding conscientious objection:

Unique among story moral trends as reflected in later political outcomes, on the topic of conscientious objection rights it was the less-published position of *Protection* narratives that was ultimately reflected in law instead of the more-published position of *Freedom* narratives. Consistent with the preferences of *Protection* narratives, in neither the 2016 nor 2021 version of Canadian MAID law were the conscientious objection rights of health workers formally restricted. Specific policies regulating the professional obligations of health workers seemed to fall instead to the authority of non-governmental medical associations, and these varied across the country. Most prominently and federally speaking, the Canadian Medical Association (CMA's) policy document asserted that at least from the CMA's perspective regarding MAID:

> i. physicians are not required to provide it, or to otherwise participate in it, or to refer the patient to a physician or a medical administrator who will provide assistance in dying to the patient; but
> ii. are still required to fulfill their duty of non-abandonment by responding to a patient's request for assistance in dying. (Canadian Medical Association, 2017).

The CMA distinguished a physician's obligation of "responding to" a MAID request from providing or referring for MAID by laying out the following as obligatory responses, including from conscientiously objecting physicians: providing the patient with "complete information on all options available, including assistance in dying"; advising the patient on "how to access any separate central information, counselling and referral service"; and, if the patient requests to be transferred to another physician or institution, facilitating that transfer in the usual way (i.e. transferring records to those authorized by the patient to receive them). In effect, then, the CMA seemed to suggest that advising a patient of how to access a referral service (and transferring medical records if requested/authorized by the patient) is within the scope of what is necessary to constitute "non-abandonment", whereas performing the referral personally is not within the scope.

Notwithstanding this position of the CMA, provincial colleges of physicians and surgeons have taken different approaches to regulating MAID in their local jurisdictions. Notably, Ontario and British Columbia have differed. In Ontario, the CPSO (College of Physicians and Surgeons of Ontario) agrees that a physician with a conscientious objection is not required to provide MAID "in any circumstances" (CPSO, 2021). However, the CPSO requires physicians to provide effective referrals for MAID, even if the physician objects as a matter of conscience or religion (CPSO, 2021). The Ontario Divisional Court reinforced this policy in 2018, ruling that the CPSO was within its rights to limit the religious freedoms of doctors beyond the scope supported by the CMA, on the rationale that requiring conscientious objectors to practice "effective referral" was "necessary to prevent harm and inequitable access for patients" (Glauser, 2018).

British Columbia's College of Physicians and Surgeons, on the other hand, has set policy that seems more closely aligned with the CMA's policy document. In British Columbia, conscientiously objecting physicians may abstain from performing MAID and from assessing their patient's eligibility for MAID, and are "not required to make a formal referral on behalf of their patient" (CPSBC, 2021, p. 5). At the same time (consistent with the CMA's policy document), British Columbian physicians are required to give their patients enough "information and assistance to allow them to make informed choices for themselves," including advising the patient that "other physicians may be available to see them, and/or directing them to an agency or health authority" (CPSBC, 2021, p. 5). Effectively, the British Columbian college of physicians seems to suggest that while the "duty of care" indeed renders it unacceptable to "abandon" a patient, the physician is not in fact abandoning a patient even if refusing to formally refer for MAID, so long as the physician at least directs the patient to a health authority. (The health authority would then presumably discuss options with the patient, and (if the patient desires) help to connect the patient to a physician who does not morally object to assessing eligibility for, and referring for, MAID.) The main difference between Ontario's policy and British

Columbia's policy seems to be the provincial interpretation of "abandonment of care." Ontario's college considers it "abandonment of care" to refuse to perform the act of referral to a non-objecting physician or agency, whereas British Columbia's college considers the duty of care sufficiently met so long as a patient is informed of means by which they may self-refer.

Proposed Areas for Future Research

Economic correlates of 'Right-to-Die' policy adoption

Having considered concerns expressed by *Protection* characters about subtle pressures tilting vulnerable persons towards choosing MAID, and taking seriously the economic observations raised by Titterington et al. (2013), I suggest future research should replicate the research methods of Titterington et al., but with an updated dataset. Several new jurisdictions have legalized either suicide assistance or active + direct euthanasia (or both) in the years since their original study. More data should now be available to assess whether state adoption of 'right to die' policies continues to correspond with economically challenged healthcare systems more than with mere population aging. Additionally, ongoing investigation into the availability of high quality palliative care would seem appropriate – and, with MAID for mental illness set for implementation in March 2023, investigation into the status of efforts to systematically improve mental healthcare in Canada.

If evidence continues to suggest that those jurisdictions legalizing MAID are doing so in significant part to conserve economic resources of already challenged healthcare systems, this would seem to warrant close scrutiny of the end-of-life policy actions prioritized by Canadian policy makers, and of the new categories of persons for whom MAID access is expanded. Questions for investigation might include: Will these be categories of persons with particularly complicated conditions, expensive to manage? Will we see measurable improvements in the quality of palliative, home care, or other supports actually "available" for those for whom MAID is now an option? What forms of care (if any) do those offered MAID say they wish they were offered as an "available" alternative? Will the balance of Canadian policy actions tend toward those that require new expenditures, or those that result in economic cost-savings? Who will experience cost-savings, and who will experience externalized costs?

Social correlates of MAID uptake by individuals

Health Canada reports (among other demographic insights) that the highest percentage of MAID deaths in Canada occur when a person is between the ages of 65-70[25] (Health Canada, 2019). The average age of retirement in Canada is 64.5 as of 2020[26] (Statistics Canada, 2021), and the academic literature review and media narrative content suggest a connection between social isolation, feelings of dependence and unproductivity, and suicide. Based on these factors, I would suggest future study of individual motivations for MAID in Canada. Qualitative interviewing with MAID seekers might shed light on whether Canadian MAID requests seem correlated with, for example, particularly difficult transitions into retirement. Such qualitative interviewing might consider factors such as increased social isolation, and would (sensitively) seek to learn the stories of persons choosing MAID in Canada, beyond the stories told by those few individuals comfortable giving publicity interviews to media or self-publishing a "manifesto."

Conclusion

This Qualitative NPF analysis systematically broke down one decade's worth of media policy narratives debating Medical Assistance in Dying (MAID) overlapping the time period during which the most political change occurred on this topic in Canada. This research particularly examined variations in narrative elements such as characterization and story moral, to identify similarities and differences in plot and narrative strategy between the policy camps discursively competing for narrative dominance about this contentious topic. This Q-NPF analysis, with its incorporation of

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[25] With the exception of the 6 month period between January 1 to June 30, 2017, when the highest percentage of MAID deaths occurred for persons between 55-64.

[26] With an average retirement age of 68 for the self-employed, 64.7 for private sector employees, and 62.4 for public sector employees.

grounded theory for enabling the identification of emergent strategies, demonstrated that not only did the competing policy camps (*Freedom, Protection,* and *Fence-sitting*) tell different stories about MAID, but the techniques by which they told these stories differed in sometimes unanticipated ways, and sometimes changed across time, as political developments altered the status quo and opened up new discursive possibilities. This project's adaptation of the QNPF method to incorporate frequency counting of narrative elements enhanced the analysis by distinguishing dominant from fringe narrative elements, illuminating volume differences of camp representation (including across subgenres), and enabling tracking of increased or decreased popularity of narrative elements across time.

By a transparent process, these methods produced a data-rich set of findings that enable a reader to assess this research for confirmability, dependability, and credibility, and to assess whether transfer of results seems possible to another area of focus. Regarding MAID, these methods demonstrated their salience and predictive power by anticipating the political shift towards expansionism of MAID after initial legalization, and the general political preference for promoting the more-published *Freedom* narrative goals than the less-published *Protection* narrative goals. The notable exception to this was the failure of the *Freedom* narrative to fully achieve its goal of legally limiting conscientious objection rights for health workers, suggesting intervening factors influenced political action in this area beyond what was reflected in media narratives.

Ultimately, the Q-NPF method illuminated areas of both contention and common ground between the three narrative camps here analyzed, and corroborated the academic literature in some areas while providing findings that questioned the literature in other areas. Emergent from this research are significant amounts of data, fruitful both for further direct analysis and for the development of new research questions, contributing both to the literature on Q-NPF analysis more generally, and to research about euthanasia narratives more specifically. It is my hope that this research has shone light on a topic too often characterized only by heat, and that each reader, regardless of starting positionality, will find within these pages something useful to take forward and turn towards a good purpose.

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