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Agony in the news media: Framing the dying body in euthanasia news coverage from Portugal and the United Kingdom (2016–2024)

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Abstract

Some studies suggest that the news media coverage of euthanasia frames the dying body as a horrible, untreatable, and intolerable bodily state. This study analyses the framing of the dying body, its organic dysfunction, and the profiles of terminal and end of life people in the euthanasia debate in Portugal and the United Kingdom. The sample includes 72 stories containing references to organ dysfunctions caused by terminal and end of life illnesses and published between 2016 and 2024 in the news media *Público*, *Expresso*, *The Guardian*, and *The Telegraph*. Content analysis and argumentative discourse analysis were combined and guided by the seminal work of Street and Kissane. The narratives employ frames that depict the body as dependent, shameful, symptomatic, temporal, and accepting. These frames highlight the decline of the body, suffering, and confinement at home. The findings underline the need for enhanced journalistic practices when addressing end of life issues.

Keywords

news media, journalism, euthanasia, assisted dying, agony, end of life, terminal stage, dying body, Portugal, United Kingdom

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Introduction

News media organisations shape public discourse through deliberate selection practices. They evaluate and choose stories based on professional conventions and values (Tuchman, 1978), prioritising issues deemed socially pressing (Habermas, 1997) or likely to engage audiences and generate commercial returns (O'Neill and Harcup, 2009). Editors also weigh how stories will benefit their readers (McQuail, 2003). This editorial gatekeeping function has profound consequences. It determines whether a topic receives sustained media attention or remains marginalised, shapes how issues are presented to the public, and decides which voices are heard in the mediated public sphere (De Vreese, 2005; Lee, 2009).

Framing is the process through which journalists select and emphasise certain elements of a story whilst downplaying others. Entman (2007: 164) defines this as "the process of culling a few elements of perceived reality and assembling a narrative that highlights connections among them to promote a particular interpretation". This selective process is consequential: it shapes what audiences notice, understand, and ultimately believe. In euthanasia coverage, research demonstrates that frames powerfully steer public discourse (Costa et al., 2025). Pro-euthanasia narratives typically foreground individual autonomy and relief from suffering, presenting death as a means of dignity and control. Anti-euthanasia frames, by contrast, prioritise palliative care investment and warn of risks to vulnerable populations. These competing narratives reveal how frames function as vehicles of power—they construct social reality and establish the link between news production and consumption (Graber, 1989). By offering audiences a shared language for evaluating end of life questions, frames ultimately shape collective understandings and identities around this contested moral issue (Brekhus, 2015).

Media discourses on contested issues reflect multiple voices, diverse perspectives, and competing interpretations (Aakhus et al., 2016). Euthanasia is not an exception to this. Sumiala (2022) has termed this phenomenon the "new social reality of public death". Media portrayals of suffering and mercy have assumed prominence in public debates concerning end of life decisions. This phenomenon has been examined by scholars in the context of news media coverage of euthanasia (Lauffer and Baker, 2020; Weicht and Forchtner, 2023). However, the focus of these studies has been on the broader themes of euthanasia, rather than on the specific way in which journalists frame the concept of the dying body. Frames operate along a spectrum of values (D'Angelo, 2002; Entman, 2007). Some constrain—emphasising decline and vulnerability. Others enable foregrounding autonomy and dignity. Still others remain descriptive, categorising embodied experiences without overt moral judgement. This tripartite distinction matters: it reveals how competing frames deploy different interpretive resources to shape understanding of euthanasia in the public sphere.

Only two studies have undertaken this analysis, and both examined Australian news media. Street and Kissane (2001) conducted a systematic discourse analysis of textual materials from seven euthanasia deaths, identifying four foundational frames that capture how the dying body is discursively constructed. These are presented in Table 1.

McInerney (2007) examined news media representations specifically, focusing on Australian coverage. Her analysis revealed a distinct aesthetic-embodiment taxonomy:

Table 1. Frames of the dying body in Street and Kissane (2001).

Frame	Definition
Symptomatic body	Captures the experience of pain and physical decline.
Dependent body	Emphasises loss of autonomy and fear of burden.
Shameful body	Highlights bodily indignity and loss of integrity.
Temporal body	Marks the compressed timeframe and "right timing" of terminal illness.

the grotesque death frame (bodily decay depicted as repulsive and uncontrollable), the messy death frame (emphasising failed attempts and bodily harm), the beautiful death frame (requested death as dignified restoration), and the glorious death frame (euthanasia as peaceful transcendence). These two studies diverge fundamentally. Street and Kissane (2001) traced lived discourses about embodied experience across institutional and public texts. McInerney (2007) examined how news media narratives aestheticise bodily decay to justify euthanasia. This analytical divergence is considerable: no comparative study has examined how different countries' news media traditions frame the dying body in euthanasia debates (Costa et al., 2025). The present study fills this gap.

Medically assisted death tends to refer to practices intended to end the life of a person with an incurable disease facing unbearable suffering. Nevertheless, definitions and boundaries can differ across legal, clinical, and cultural contexts (Jaye et al., 2021). Typically, such practices may be divided into two main categories. The first is euthanasia, most often understood as the administration of a lethal dose of medication by a physician. The second is assisted suicide, in which the individual self-administers the medication provided for that purpose. In this research, the term "euthanasia" is used in a broad sense, encompassing all forms of medically assisted death. This reflects the fact that, in academic, journalistic, and policy debates, the term is frequently employed as a general synonym for these practices.

Public support for euthanasia legislation has grown substantially in both Portugal and the UK. According to the 2022 European Values Study, British citizens score 6.55 points on average regarding euthanasia justification, compared with Portuguese citizens, who average 4.86 points (Costa, 2025). Both scores are measured on a Likert-type scale ranging from 1 ("never justified") to 10 ("always justified"), where higher values indicate greater endorsement of the practice. These mean scores are calculated from respondents' individual responses. Yet legislative progress has taken markedly different paths, reflecting distinct medical and ethical frameworks in each country.

In Portugal, Parliament approved the legalisation in May 2023 (Lei n.o 22/2023, 2023), permitting two distinct practices: "medically assisted suicide" (where the patient self-administers lethal medication under medical supervision) and "voluntary active euthanasia" (where a physician administers the lethal medication). This approval occurred after a lengthy legislative process involving several versions of the bill, multiple reviews by the Constitutional Court, and presidential vetoes. When the Portuguese Constitutional Court subsequently reviewed specific norms of the law in April 2025—prompted by Social Democratic MPs and the Ombudsman—it did not suspend the process pending government formation (Lusa and Alves, 2025). Instead, the Court declared certain rules

Table 2. Temporal classification of end of life stages.

Temporal stage	Duration	Key characteristics
End of life	~Last year of life	Challenges in pain management, the complexity of symptoms, and emotional and psychological distress indicate that palliative care is increasingly required.
Terminal	~Last 6 months	This includes advanced cancers such as pancreatic, lung, or oesophageal; neurodegenerative diseases such as motor neurone disease; and other conditions that vary depending on the specific jurisdictions in which euthanasia is legally permitted.
Agony	Final days to hours	Multiple concurrent physical changes are evident in the final stages of active dying, such as delirium, respiratory distress, and severe pain.

unconstitutional with mandatory general force, notably those concerning the physician's discretion in choosing the method and the mandatory precedence of assisted suicide over euthanasia. Consequently, the law is not yet in force. Its implementation is contingent on the Parliament amending the norms declared unconstitutional by the Constitutional Court and the Government approving the necessary operational regulations.

In the UK, the "Terminally Ill Adults (End of Life) Bill" advances a narrower vision of the topic. The framework allows terminally ill patients to receive medication prescribed by a physician, which the patient then self-administers. The bill has progressed through Parliament. It passed its second reading in November 2024, completed the Commons with a third reading in June 2025, and now faces scrutiny in the House of Lords (BBC, 2025). Public figures have shaped this debate. Television presenter Dame Esther Rantzen gave the discussion new impetus by publicly announcing her membership in the Swiss clinic *Dignitas* and declaring her intention to pursue euthanasia should her lung cancer become untreatable. Her announcement prompted widespread public response. Within weeks, over 200,000 people signed a petition calling for parliamentary debate on the matter, which successfully triggered a parliamentary session.

In countries where this medical procedure is legal, terminal oncological diseases remain the most frequent reason for euthanasia requests (Rahimian et al., 2024). Understanding the clinical trajectory of end of life care requires distinguishing three temporal phases (Barosa et al., 2021; Ohinata et al., 2022). Table 2 below outlines these phases and their key characteristics.

The incidence of oncological disease remains significant globally. Cancer cases continue to rise, making it the second leading cause of death worldwide. Approximately 50% of the British population (Smittenaar et al., 2016) and 25% of the Portuguese population (Carrapatoso and Sampaio, 2022) will develop cancer during their lifetime. The agony stage is particularly prevalent: 70.7% of deaths in Portugal experience this final stage (Gomes et al., 2018), rising to 90% in the UK (Marie Curie, 2023).

To investigate comparatively the framing of the dying body in the euthanasia debate within different journalistic contexts, while expanding existing knowledge and addressing a gap in the literature, this study aims to answer the following research question: How do

Portuguese and British news media frame the dying body and its organ dysfunction in the end of life stages within the topic of euthanasia? Understanding these frames across different media contexts matters because media narratives can shape how societies imagine dying, how people form attitudes towards euthanasia, and ultimately how policymakers regulate end of life care (Costa et al., 2026a). A clearer understanding of these frames can contribute to more responsible communication around euthanasia and dying.

Literature review

From death to euthanasia

Early research on media death narratives identified that news coverage privileges the deaths of prominent figures and ordinary citizens in circumstances perceived as extraordinary or meaningful (Walter et al., 1995). This observation finds critical elaboration in Herman and Chomsky's (1988) analysis of media political economy, which reveals how journalism systematically constructs hierarchies of visibility. Their framework distinguishes between "worthy victims"—those subjected to abuses in adversary states, who receive detailed scrutiny and demands for accountability—and "unworthy victims"—those subjected to abuses perpetrated by the media organisation's own state or its strategic allies, whose suffering receives diminished coverage. Despite transformations in contemporary media landscapes, this hierarchical structure remains operative. Sumiala (2022) documents that whilst death has become increasingly hypermediated and narratives centring suffering and mercy now proliferate across platforms, the foundational logic of victim hierarchisation persists structurally unchanged. Certain deaths acquire disproportionate public prominence; others remain systematically marginalised.

Recently, stories of British citizens travelling to Switzerland in search of euthanasia have frequently appeared in the media (Carrigan, 2023). The *Dignitas* clinic, located in the canton of Zurich, has occupied a central position in the euthanasia debate after becoming the first organisation to allow foreigners to access this option in Switzerland (Gauthier et al., 2015). Media coverage of these cases reflects Switzerland's representation as a liberal jurisdiction that permits medicalised approaches to death—emphasising individual autonomy and medical authority—and constructs British citizens as the paradigmatic subjects of this practice in public discourse (Carrigan, 2023).

Brassolotto et al. (2023) found that media framing is contextual and changes over time according to the country's social, political, economic, and medical circumstances. Prior to the legalisation of euthanasia in Canada, media discourse revealed substantive differences (Burlone and Richmond, 2018): those in favour (60%) emphasised individual autonomy and dignity as taking precedence, whilst those against (36%) invoked sanctity of life and the slippery-slope argument concerning normative and legal expansion. Media coverage also demonstrated how disability is discursively constructed within discussions of euthanasia. Analysis of Canadian news media coverage revealed a systematic pattern wherein disability was conflated with terminal illness. Specifically, coverage of the 2004–2006 case of Charles Fariala, a man with multiple sclerosis whose mother, Marielle Houle, was accused of assisting him in committing suicide, exemplified this framing (Schwartz and Lutfiyya, 2009). News media portrayed his disabling

condition as a fate worse than death: "As the effects of multiple sclerosis began to ravage his athletic body, Charles Fariala was adamant that he would not live with the burning pain in his legs, nor [with] the stares of others" (Wilton, 2006: A6). Although Fariala was not at the end of his life, media narratives emphasised bodily deterioration and loss of function without engaging substantive disability perspectives, thereby legitimising assisted suicide (Schwartz and Lutfiyya, 2009). After legalisation in Canada, media framings shifted to prioritise institutional resistance and conscientious objection among healthcare providers (Knox and Wagg, 2023).

Similar patterns in media framing have been observed in other national contexts where euthanasia has been legalised. In the first countries to authorise euthanasia (such as Belgium and the Netherlands, as well as some US states), news media coverage has historically emphasised the personal and emotional dimensions of death, particularly in cases of oncological disease, as well as political and institutional discussions (Rietjens et al., 2013; Van Brussel et al., 2014). This focus on individual narratives and lived experience has evolved over time. One prominent example is the case of Brittany Maynard. A 29-year-old American woman diagnosed with terminal brain cancer decided to move to Oregon to legally access euthanasia. Lauffer and Baker (2020) demonstrate that the coverage of her death in 2014 produced three dominant frames: tragic figure, peaceful death, and legacy of choice. Portrayed as an attractive, newly married young woman, the narrative shifted from an episodic frame (the specific act of choosing euthanasia) to a thematic one (a broader discussion of the right to die), reinforcing the idea of end of life decisions as acts of personal agency and an alternative to traditional medical pathways.

Weicht and Forchtner (2023) argue that ideological positions are associated with different strategies of argument about good/bad and right/wrong, defining different visions of dying and fostering processes of demarcation between the "self" and the "other". The most frequent argument in favour of euthanasia in the media includes the person's self-determination to achieve a good death. The most frequent arguments against say that suffering must be alleviated by investment in palliative care, because euthanasia accentuates the marginalisation of vulnerable groups. Generally, the frames in favour articulate liberal autonomy and dignity as something that can be obtained, retained, or lost (Van Brussel, 2014). The celebration of the heroism of the subject who autonomously chooses how and when to die, especially when they are fully conscious in their decision-making, may limit the visibility of alternative ways of dying—particularly palliative care approaches emphasising gradual, natural death accompanied by community care, or deaths involving diminished awareness and autonomy. Van Brussel and Carpentier's (2012) analysis of Belgian news media coverage demonstrates that this celebration of autonomous death through euthanasia is accompanied by the symbolic annihilation of other dying trajectories, effectively disciplining those whose deaths do not conform to this heroic ideal. People who choose euthanasia are portrayed as elements of resistance to existing hegemonic religious, medical, and legislative views on end of life decisions (Lauffer and Baker, 2020).

Framing the dying body

The dying body holds particular news value because of the drama and crisis generated within families facing terminal illness. The body in disarray becomes a vehicle for media

narratives that emphasise decline and deterioration (McInerney, 2007). Dying alone is portrayed as a terrible fate, attributed either to personal failure or societal breakdown (Seale, 2004), and receives disproportionate media attention compared to accompanied deaths (Nelson-Becker and Victor, 2020). The portrayal of activists as heroes reinforces legalisation demands. In these narratives, euthanasia is depicted as a means of arresting physical deterioration, thereby shaping public understanding of what constitutes an acceptable death (McInerney, 2006).

Court cases involving family assistance in suicide reveal systematic patterns of media framing. Deaths caused by degenerative diseases are presented as aberrant conditions. The individuals' failed suicide attempts are systematically obscured—rendered invisible—so that the final death appears cleanly executed and predetermined (Banerjee and Birenbaum-Carmeli, 2007). Terminally ill persons and their families are framed as autonomous, fully aware individuals. This framing is accompanied by celebratory descriptions: idyllic family relationships, law portrayed as outdated, and praise for lenient judicial decisions (Birenbaum-Carmeli et al., 2006). Journalistic consensus-building constrains the discursive space available to dissent. Opposing positions appear as decontextualised terminal quotations. Their peripheral placement and brevity render them epistemically inert within the predominant pro-euthanasia framework (Banerjee and Birenbaum-Carmeli, 2007).

Building on Street and Kissane (2001)'s foundational typology (outlined in Table 1) and the broader literature (Costa et al., 2025), this study advances current understanding by examining how the most widely read news media frames the dying body and its organic dysfunction across different national contexts. In doing so, the investigation contributes to the interdisciplinary field of death and media studies by offering a comparative perspective that highlights cultural specificities and transnational frames in the public representation of end of life suffering.

Method

This study comparatively examines how journalism in Portugal and the UK frames the dying body in euthanasia coverage. The two countries operate within distinct media systems. According to Hallin and Mancini (2004), Portugal exemplifies the pluralistic mediterranean model, where journalism exhibits lower levels of professionalisation, stronger political parallelism, and reduced editorial autonomy. The UK, by contrast, typifies the liberal model—marked by professionalised and commercialised journalism with greater independence from political pressure.

The publications selected represent the most widely read outlets in each country, encompassing ideologies across the political spectrum. In Portugal, *Público* and *Expresso* are generally seen as politically neutral (Costa and Antunes, 2024). In the UK, *The Guardian* leans centre-left, whilst *The Telegraph* leans centre-right (Garcia-Blanco and Bennett, 2021). *The Sunday* editions—*The Observer* and *The Sunday Telegraph*—were also included because their editorial voices frequently diverge from their weekday counterparts, offering distinct analytical perspectives.

The sample included news stories on euthanasia containing references to organ dysfunction caused by terminal illness and end of life published online between 1 January

2016 and 1 January 2024. These 8 years cover the 2 years prior to the parliamentary debate on the first bill to decriminalise euthanasia in the Portuguese parliament (2018) and overlap with the period without published research on the role of the British media in the evolution of public discussion on euthanasia.

A Python-based tool interfacing with *The Guardian*'s API was used to extract stories in PDF format (Santos, 2024). The automated search employed the following terms: "euthanasia", "medically assisted death", "assisted suicide", "assisted dying", "palliative care", "pain and agony", "end of life care", "terminal illness", "mercy killing", "right to die", "euthanasia tourism", "death tourism", "assisted suicide abroad", and "suicide trip". A researcher supervised this process, excluding all stories whose primary focus was not euthanasia. Because this method was applied only to *The Guardian*, extractions from the remaining outlets—*Expresso*, *Público*, and *The Telegraph*—were performed manually through each publication's website search engine using identical search terms. The initial collection yielded 1731 stories: 616 from *Expresso*, 502 from *Público*, 400 from *The Guardian*, and 213 from *The Telegraph*. Subsequently, 1659 stories were excluded for failing to reference organic dysfunction caused by terminal or end of life illnesses. The final sample comprised 72 stories: 31 from *The Guardian*, 17 from *Expresso*, 12 from *Público*, and 12 from *The Telegraph*.

Content analysis (Mayring, 2014) and argumentative discourse analysis (Aakhus et al., 2016; Hajer, 2006) were combined. Street and Kissane (2001) applied content analysis to map patterns in relation to content, ideas, forms of language, and social structures in stories addressing the dying body on the topic of euthanasia. We performed descriptive coding of the data with simple quantitative counting of the codes (Vaismoradi et al., 2013). Argumentative discourse analysis enables the reconstruction, description, and evaluation of how arguments (individual or collective) are processed in news media for a multiparty debate (argumentative polylogue), as demonstrated in the work of Weiss (1992).

In the first coding stage, the software MAXQDA (version 24.9.1) was used to organise, code, and describe each unit of analysis according to the following categories: year, country, media, ill person characterisation, description of the agony phase, surrounding context, and frames of the dying body. In texts where there was more than one story, only those that referred to organ dysfunction and the statements of sources of information directly involved in the dying body were coded. This corresponds to the "various" category. In the characterisation of the ill person, sex was coded solely based on explicit references found within the journalistic text. When stories discussed the dying body and associated organ dysfunction of more than one person, the category "both sexes (multiple persons)" was coded. We did not infer sex from pronouns alone; coding was grounded in textual identification.

In the second stage, an in-depth analytical reading of each story was conducted to inductively identify other codes and emerging themes/frames (Vaismoradi et al., 2013). This process is called open coding, which allows unrestricted exploration of the content and the formation of new categories of analysis (Saldaña, 2016). This reiterative process involves putting similar words and parts of the story together while codes and categories are gradually created and improved based on how the data is understood (Vaismoradi et al., 2013). Through this inductive process, we identified recurrent discursive patterns regarding the dying body, which we synthesised into five overarching frames: the body

as symptomatic, the body as dependent, the body as shameful, the body as temporal, and the accepting body. Each frame encompasses multiple sub-themes and sub-codes that were gradually refined through iterative coding.

In the third stage, axial coding was employed to refine and group the codes into broad categories and develop the final themes/frames (Saldaña, 2016). Individual stories were classified according to which frame(s) was dominant in their narrative construction. Importantly, stories frequently mobilised multiple frames simultaneously; a single story could be coded under two or more frames depending on how the dying body was discursively constructed across different sections of the text. Frame assignment was not mutually exclusive but rather reflected the interpretive reality of how euthanasia narratives in journalism operate—complex and multivalent. The fifth frame, the accepting body, emerged inductively from data that presented neither clearly symptomatic, dependent, shameful, nor temporal framings, instead addressing existential dimensions of bodily decline and human agency in the face of natural degeneration. In the fourth stage, each story was reread, using developed themes to guide and refine the analysis (Table 3).

Two researchers conducted the coding stages collaboratively to ensure inter-coder reliability. Our disciplinary backgrounds differed significantly—one researcher trained in media studies, the other in marketing—which may shape our analytical lenses. Where media studies expertise emphasises textual and institutional analysis, marketing expertise brings particular sensitivity to audience reception, persuasive messaging, and narrative construction. We recognised these positionalities as potential sources of bias in frame identification and dying body characterisation. To mitigate this risk, we employed a structured collaborative approach: each researcher coded independently, then engaged in systematic discussion to build consensus. When disagreements arose—and several did—we returned to the original text to understand our divergent readings, refined operational definitions collaboratively, and documented our reasoning. This iterative negotiation process transformed potential methodological tension into analytical strength, leveraging complementary perspectives to produce more robust coding decisions (Saldaña, 2016).

Results and discussion

Framing the dying body in the terminal phase and at the end of life

The results show that 59.7% of the stories were published in the UK, 22.2% in the year 2023, and 43.1% in *The Guardian* (Table 4). The frames of the dying body in the terminal phase and at the end of life relate to experiences of death associated with euthanasia, of people who want to be euthanised, and of sources of information that refer to the organic dysfunction of the body to situate their experiences with death and make reflections on the subject. Particular cases (40.3%), discussion/voting on draft law (20.8%), debate on legalising euthanasia (18.1%), social and medical issues (11.1%), approval/revision of the assisted dying law (6.9%), and suspicions of euthanasia in the NHS (2.8%) are the contexts and events behind the stories.

Pain (26.1%) and disease progression to other organs (9.8%) are the symptoms most often mentioned to describe organ dysfunction (Table 5). The stories were presented through five frames (Table 6): the body as dependent (43.3%), the body as shameful

Table 3. Distinctive traces of each frame, including core concepts, thematic elements, typical linguistic markers, and narrative voices.

Frame	Core concepts	Thematic elements	Typical linguistic markers	Narrative voices
The body as dependent	Loss of control Independence Fear of burden	Desire for control over death Fear of loss of independence Fear of being a burden Inability to perform basic functions Being "trapped" or "entombed" in a body Reliance on others for personal care	Trapped in own body Entombed No control Wear nappies Need to be fed/cleaned Dependence on ventilator	Patient voice Personal desires and fears about dependence
The body as shameful	Indignity Degradation Loss of dignity	Prolonged suffering without meaning Loss of dignity Theological/existential suffering Body becoming unrecognisable Dying with dignity versus agony Unnatural prolongation of biological life	Falling apart Senseless agony Denied dignity Prolonging suffering Living corpse Degradation	Family/journalist voice Reflections on witnessed suffering
The body as symptomatic	Medical perspective—symptoms Disease progression Professional witness	Medical symptoms and progression Health professionals' powerlessness Professional witness to extreme suffering Lists of symptoms/treatments Doctor-patient relationship Palliative care limitations	Dyspnea Lymphoma Metastasised Palliative care Doctor as narrator Inability to control pain despite medication	Health professional voice Doctors/nurses describing patient suffering
The body as temporal	Time-bound body—past versus present Memory versus degradation	Contrast between past and present Progressive deterioration over time Gradual loss of faculties Past vitality versus present frailty The body as a marker of time passing	Before he was. . . now he is The body no longer responded Disease progression Deterioration over time Gradually lost ability	Family/journalist voice Observing change over time
The accepting body	Acceptance Resilience Fighting spirit	Choosing to keep fighting Living well with illness Maintaining dignity through acceptance Resistance against giving up Quality of life despite illness	Chose to keep fighting Lived remarkably well Did not give up Maintaining control Acceptance of illness	Patient/family voice Positive framing of illness experience

Table 4. Distribution of the sample by country, media, and year.

Variable		*n*	%
Country	United Kingdom	43	59.7
	Portugal	29	40.3
	Total	72	100.0
Media	*The Guardian*	31	43.1
	Expresso	17	23.6
	Público	12	16.7
	The Telegraph	12	16.7
	Total	72	100.0
Year	2016	9	12.5
	2017	9	12.5
	2018	11	15.3
	2019	2	2.8
	2020	11	15.3
	2021	6	8.3
	2022	8	11.1
	2023	16	22.2
	Total	72	100.0

Table 5. Number of coded segments per code in the *description of the organ dysfunction* category.

Description of the organ dysfunction	*n*	%
Pain	61	26.1
Disease progression to other organs	23	9.8
Difficulty swallowing	20	8.5
Psycho-emotional symptoms	18	7.7
Physical changes	17	7.3
Decreased intake of food and fluids	15	6.4
Fatigue and weakness	13	5.6
Decreased level of consciousness	11	4.7
Fluids and odours	11	4.7
Breathing difficulties	7	3.0
Moaning	7	3.0
Increase of oropharyngeal secretions	6	2.6
Terminal delirium or agitation	6	2.6
Nausea and vomiting	6	2.6
Seizures	5	2.1
Respiratory changes	3	1.3
Difficulty of recognition	3	1.3
Last few hours with cardiovascular changes	1	0.4
Haemorrhages	1	0.4
Total	234	100.0

Table 6. Distribution of stories in each frame across countries and news outlets.

		Country and news source									
		Portugal				United Kingdom					
		Expresso		*Público*		*The Guardian*		*The Telegraph*		Total	
		n	%	*n*	%	*n*	%	*n*	%	*n*	%
Frame	The body as dependent	6	22.2	8	33.3	22	44.0	19	73.1	55	43.3
	The body as shameful	0	0.0	10	41.7	12	24.0	1	3.8	23	18.1
	The body as symptomatic	11	40.7	3	12.5	3	6.0	0	0.0	17	13.4
	The body as temporal	5	18.5	1	4.2	1	2.0	2	7.7	9	7.1
	The accepting body	3	11.1	1	4.2	2	4.0	0	0.0	6	4.7
	It's not possible to say	1	3.7	0	0.0	9	18.0	3	11.5	13	10.2
	Not applicable	1	3.7	1	4.2	1	2.0	1	3.8	4	3.1
	Total	27	100.0	24	100.0	50	100.0	26	100.0	127	100.0

(18.1%), the body as symptomatic (13.4%), the body as temporal (7.1%), and the accepting body (4.7%). The last frame is the main new finding in relation to the seminal study by Street and Kissane (2001). These social imaginaries are associated with a diverse argumentative structure towards euthanasia and mobilise in different ways the description of the organ dysfunction. In the following sections, a distinction will be made according to each frame. In 10.2% of the stories, we could not assign any frame to the descriptions of organic dysfunction. These cases involved ambiguous or unclear statements regarding the dying body that did not align with our existing frames nor constituted sufficient thematic coherence to warrant development of an additional frame. The "not applicable" category (3.1%) refers to stories that make only abstract reference to organic dysfunction of the dying body, without substantive narrative engagement with bodily decline.

In 83.3% of the stories, information about the religiosity of the persons described in relation to organic dysfunction caused by terminal and end of life illnesses is absent (Table 7). Substantial information gaps also exist regarding level of education (77.8%), nationality (69.4%), relationship status (59.7%), ethnic group (55.6%), age (31.9%), and ill person environment (30.6%). Despite these gaps, the available data reveals that 45.8% of the persons had a clinical diagnosis of cancer, 38.9% were female, 25.0% were older adults (⩾65 years), 25.0% were Caucasian, 20.8% were married, 20.8% were house-bound, 6.9% were British, and 6.9% had higher education.

The analysis that follows examines narrative frames evident within our dataset. Given our qualitative research design and sample composition, these findings are presented as illustrative of textual patterns within our corpus rather than as statistically representative of Portuguese or UK news media more broadly. Individual stories frequently embody multiple frames simultaneously, and narratives typically interweave different rhetorical strategies.

Frame of the body as dependent

The frame of the body as dependent reflects concerns associated with the desire for control, worries about losing independence, and the fear of being a burden (Street and Kissane, 2001). In the desire for control, the sources of information argue that euthanasia allows an end to the physical degradation and pain of ill people. "Nobody talks about how awful, how truly awful the details of this condition are, and the ignominy that is attached to it. Well, it's high time they did. . . This means giving human beings political autonomy over their own death"[1] (Stirling, 2023).

The concern about loss of independence is framed by progressive family changes—quitting jobs, moving house, postponing surgery, becoming an informal carer, among others—resulting from the ill persons' growing inability to carry out basic daily activities—self-care, eating, drinking, walking, among others. Individuals are simultaneously presented with portraits of life before the disease, conveying that the current condition of physical dependence imprisons independence, privacy, intimacy about their bodies, and quality of life. The story of a Spanish citizen who assisted the mercy suicide of his wife with terminal multiple sclerosis was framed as follows:

Table 7. Ill person characterisation.

Variable		*n*	%
Nationality	British	5	6.9
	Other	5	6.9
	Various	3	4.2
	It's not possible to say	50	69.4
	Not applicable	9	12.5
	Total	72	100.0
Sex	Women	28	38.9
	Men	25	34.7
	Both sexes (multiple persons)	8	11.1
	Not applicable	9	12.5
	Total	72	100.0
Age	Older adults (⩾65 years)	18	25.0
	Adults (20–64 years)	14	19.4
	Various	8	11.1
	It's not possible to say	23	31.9
	Not applicable	9	12.5
	Total	72	100.0
Ethnic group	Caucasian	18	25.0
	Various	3	4.2
	Afro-descendant	1	1.4
	It's not possible to say	40	55.6
	Not applicable	10	13.9
	Total	72	100.0
Level of education	Higher education	5	6.9
	Various	2	2.8
	It's not possible to say	56	77.8
	Not applicable	9	12.5
	Total	72	100.0
Relationship status	Married	15	20.8
	Various	4	5.6
	Divorced	1	1.4
	It's not possible to say	43	59.7
	Not applicable	9	12.5
	Total	72	100.0
Religiosity	Various	2	2.8
	Atheist	1	1.4
	It's not possible to say	60	83.3
	Not applicable	9	12.5
	Total	72	100.0

(continued)

Table 7. (continued)

Variable		*n*	%
Clinical information	Cancer	33	45.8
	Neuromuscular disease	10	13.9
	Various	9	12.5
	Alzheimer's and related dementias	4	5.6
	Infectious and parasitic diseases	1	1.4
	It's not possible to say	6	8.3
	Not applicable	9	12.5
	Total	72	100.0
Ill person environment	Home	15	20.8
	Various	9	12.5
	Hospital	8	11.1
	Palliative care	5	6.9
	Residential care	4	5.6
	It's not possible to say	22	30.6
	Not applicable	9	12.5
	Total	72	100.0

> Her case had already been told before to "El País", where Maria José's other life was described. That of an active woman, a legal secretary by profession, whose illness deprived her of both small and great pleasures, forcing her to put aside her brushes and canvases, and even the piano where she liked to play. That was just the beginning. Then came the inability to move around; the doors in the house disappeared to make it easier for the wheelchair to get through until she was practically paralysed and with serious sight and hearing problems, absolutely dependent (Ganhão, 2019).

The fear of being a burden frames the idea that the people available to provide care may not be willing to take on the burden of care or that the ill persons don't feel comfortable receiving it, as demonstrated in this passage: "She was an extremely strong, independent woman who didn't want to be a burden to anyone. Of course she wasn't, neither for me nor for my sister" (Almeida, 2020).

In Portugal, narratives in this frame tend to foreground first-person testimony and detailed biographical context. The daughter's account of her father—"If he hadn't committed suicide, my father would have fallen into a bed. He would have been debilitated and in unbearable pain" (Wong, 2020)—which exemplifies how these narratives prioritise subjective experience and emotional resonance. These accounts frequently include authorial reflection and evaluative commentary. Additional testimonies illustrate this pattern. A woman describes her father as "a man who loved living and had countless goals", but "it was unthinkable to depend on anyone", expressing the explicit refusal to be seen "lying in bed, wasting away" (Wong, 2020). Another account states, "the only path would be worsening", reflecting the anticipatory distress of progressive loss (Garcia, 2022).

In the UK, narratives similarly emphasise bodily loss and the struggle for autonomy, skilfully intertwining these themes with clinical and medical descriptions. For example, Janice Hunter's story—where "leukaemia had ravaged the retired shop worker to the point that she had lost her sight, was unable to eat or walk, and needed to wear nappies" (Smith, 2022)—illustrates how UK journalistic accounts blend precise medical facts ("lost her sight", "unable to eat or walk") with emotionally charged language ("ravaged"). Additional narratives demonstrate comparable hybridity. Noel Conway describes being "entombed in my own body as my ability to move and communicate continues to diminish" (Bowcott and Sherwood, 2017), while another account states, "He is reliant for 20 hours each day on a non-invasive ventilation device and is said to feel entombed" (Bowcott, 2017). Rather than representing separate stylistic approaches, these narratives reveal differing focal points: Portuguese accounts frequently incorporate reflective commentary and explicit positioning, whereas UK narratives tend to integrate clinical documentation with emotional resonance.

This frame prioritises individual autonomy as the paramount ethical value, positioning the right to control bodily fate as fundamental to human dignity. Patients narrate suffering not primarily as physical pain but as loss of agency—the inability to author one's own existence. The frame constructs dependence as a form of existential imprisonment, rendering the body a site of violated autonomy rather than merely a site of physical distress. This rhetorical move shifts moral emphasis from pain management to self-determination, positioning euthanasia as the ultimate expression of control and dignity preservation rather than pain relief.

Frame of the body as shameful

The frame of the body as shameful relates to the breakdown of bodily integrity and the consequent inability to manage the body in a socially acceptable way (Street and Kissane, 2001). Example: "Some will retch at the stench of their own body rotting. Some will vomit their own faeces. Some will suffocate, slowly, inexorably, over several days, their last moments of life disfigured by terror" (Toynbee, 2023).

Portuguese narratives in this frame tend to emphasise philosophical and ethical reflection on dignity and mortality. The account attributed to Amaral (2017)—"A beloved face that belonged to a body that no longer responded to anything and was once so capable. I still don't understand why it wasn't possible to honour that death"—exemplifies how these stories foreground existential and relational dimensions of bodily deterioration. Additional examples illustrate this philosophical emphasis on agony as undignified: "living artificially after the natural collapse of the body is no longer living naturally. Life in a state of agony cannot be considered natural" (Gomes, 2016). "I really don't feel like surviving myself" (Campos, 2018).

UK narratives similarly foreground dignity and embodied suffering, often anchoring ethical reflection in the voices of healthcare professionals and family members describing medical failures and practical dilemmas. Sue's statement—"They can't stand up, they're too sick to speak, and they can't swallow or eat. What is the point in keeping someone alive like that when that isn't what they want? It's cruel" (McGowan, 2021)—integrates ethical reflection with practical observation of bodily dysfunction. Additional

testimonies illustrate witnessing of degradation: "It was basically dying flesh, and she was still with us. Her family's memory of her was her decomposing while she was still alive" (Toynbee, 2023). "My mother's dementia turned her into a screaming, nappy-wearing, spoon-fed shadow of her former self" (Orobitg-Baena et al., 2023). A son describes his father: "Over eight or nine years Parkinson's disease eventually wasted him to nothing" (Daley, 2016). Rather than representing categorical differences, these stories reveal different narrative anchors: Portuguese accounts tend to centre on individual philosophical reflection, while the UK inclines to anchor ethical reflection in witnessed clinical realities and relational caregiving contexts.

This frame prioritises human dignity as inviolable but constructs dignity not as resilience in suffering but as bodily intactness and social presentability. Narratives position bodily degradation—incontinence, inability to eat, physical wasting—as incompatible with dignity. The ethical claim is that certain bodily states are inherently undignified and cannot be redeemed through meaning-making or relational presence. This frame constructs suffering as dehumanising rather than transformative, making the case that intervention to end life preserves dignity precisely by preventing its total dissolution.

Frame of the body as symptomatic

The body as symptomatic frame foregrounds the medical dimensions of dying: symptoms, disease progression, and the limits of treatment. This frame is distinguished by its reliance on health professional voices—doctors and nurses who witness extreme suffering firsthand and narrate their professional helplessness in the face of patients' unrelieved distress.

In Portuguese news media, health professionals stand out as key narrators, offering medical accounts of suffering while also reflecting on their own emotional and ethical challenges. The anguish of a haematologist unable to relieve a terminally ill patient's suffering exemplifies this perspective:

> Nuno Miranda, now 57, and a haematologist at the IPO [Portuguese Institute of Oncology] in Lisbon, waited 12 long hours helplessly for dyspnoea, the result of lymphoma, to kill the boy. Lying in a hospital bed, the young man is breathing harder and harder. Each breath is smaller than the last. Breathing is pain. . . "In my professional life, I've had no more than a dozen cases. But each one has crushed me. It's not true that you can treat all suffering" (Reis and Martins, 2017).

Additional testimonies from Portuguese media capture medical limitations. One example: "A family member of mine, dying from pancreatic cancer, entered the phase the doctor considered terminal. From now on either there will be pain or we will abbreviate the pain" (Monteiro, 2016).

This frame also surfaces in narratives where medical prognoses prove inaccurate, exposing the limitations of palliative medicine. British accounts frequently feature family members as secondary witnesses to medical failures—highlighting inadequate communication, uncontrolled symptoms, and the gap between promised and actual end of life experiences:

> Mum's end of life phase was made worse by a lack of communication about the dying process. In July 2019, when she was hospitalised after a seizure, doctors told her that death would come within weeks and be gentle: she would get more and more tired until she eventually slipped away. By the time she did die, on 30 March 2020, she had endured eight months of pain, seizures, confusion, increasing paralysis and other challenging symptoms, compounded by a decreasing—and eventually non-existent—ability to communicate how she felt (Creamer, 2023).

Additional UK narratives illustrate medical failure in palliative settings. A mother describes her daughter's inadequate pain control despite aggressive medication: "Fiona's last few weeks were spent in a hospice receiving palliative care intended to reduce her pain. Despite huge amounts of drugs, she still suffered excruciating pain. . ." (Strong, 2020). A critical care nurse reflects on professional experience: "I often cared for individuals who could not live free from pain and suffering, often requiring an artificial ventilator or pharmacological support in order to survive even for a short period of time" (Bell, 2023).

The present conceptualisation is distinct from both the frame of the body as dependent, which focuses on patient autonomy, and the frame of the body as shameful, which centres on the loss of dignity. Instead, the frame of the body as symptomatic adopts a distinctly medical-professional approach. The symptoms are systematically catalogued. Treatments are outlined in detail. Suffering is described through clinical observation rather than lived experience. Consequently, the body becomes a locale for medical intervention, thereby highlighting the inherent limitations and deficiencies in clinical practice.

This frame prioritises medical truth and professional honesty as ethical foundations. It positions suffering as a medical problem but one that may be refractory—beyond the reach of available interventions. The frame constructs medical helplessness as itself an ethical crisis: professionals witness suffering they cannot relieve. This shifts the ethical burden from individual autonomy (dependent frame) or dignity preservation (shameful frame) to systemic honesty about medicine's limits. The implicit claim is that continued life-prolongation in the face of unrelieved, refractory suffering constitutes medical negligence rather than care.

Frame of the body as temporal

The frame of the body as temporal refers to the practice of euthanasia as a way of interrupting the dysregulation of the disease at the right moment before the terminal phase arrives (Street and Kissane, 2001). It encompasses degenerative diseases characterised by the progressive and irreversible deterioration of organs that cause disturbances in the biological clock and progressive motor discoordination. The temporal dimension emerges as these physical changes accumulate, rendering the individual increasingly dependent on others for care—a social consequence of physiological decline rather than a direct physical effect.

Portuguese stories in the temporal frame feature first-person accounts of individuals with degenerative illnesses, such as Huntington's disease and Parkinson's disease, articulating their anticipatory suffering and existential fear regarding loss of selfhood. These narratives centre on sick people's explicit desire not to live when they are no longer

themselves: “I don’t want to live when I’m no longer me. . . My brain will start to die. My behaviour will change. I’m going to lose my motor skills. I’m not going to be able to talk, walk, or eat anymore” (Reis, 2018). Another account describes the family pattern: “My father ended life dependent, demented, and hostile to others. . . My father suffered horrors, agonised like an animal” (Ascensão, 2022).

In the UK, narratives similarly foreground degenerative disease and temporal anticipation of decline. The account of Jackie—“For years, according to Jackie, she was able to manage the condition. But five years ago, she began to deteriorate markedly. A back operation left her in constant pain” (Brown, 2018)—documents the trajectory of functional loss through clinical detail. A man with motor neurone disease describes his accelerating decline: “Five days before he passed away”, he texted Kimberly: “MND is ripping through my body. Can hardly stand any more. I’ve lost dexterity. Lost the enjoyment of meals. Can’t speak. I can’t handle this . . . I’m deteriorating day by day” (Lu and Davey, 2023).

Portuguese first-person accounts tend to emphasise subjective existential fear (“I don’t want to live when I’m no longer me”), while UK third-person accounts tend to document progressive decline through observable symptoms and medical events. Both approaches engage the temporal dimension of degenerative illness, but through different narrative perspectives.

This frame prioritises temporal agency—the right to choose the moment and manner of death—as the ethical foundation. Unlike the dependent frame (which emphasises autonomy in general), the temporal frame makes time itself ethically critical. Narratives construct degenerative illness as a process of predictable, irreversible loss—one in which the future is knowable and foreclosed. Euthanasia becomes framed as preventive intervention: choosing death “at the right time”, before the self dissolves completely. This shifts the ethical focus from present suffering to future selfhood, positioning early death as a form of self-preservation rather than self-destruction.

Frame of the accepting body

This study identifies a frame absent from Street and Kissane’s (2001) foundational taxonomy: the accepting body. This frame characterises news narratives that challenge the discourse on euthanasia by emphasising acceptance of mortality, encouraging meaningful engagement with the time remaining, and highlighting the existential significance of the dying process. While other frames depict the body as a problem requiring intervention, control, or escape, the accepting frame reimagines it as a space where suffering gains meaning and relational connections are strengthened.

This frame emerges within Portuguese and British news contexts, showcasing distinctive features and thematic focuses that set it apart from other frames in our taxonomy. The distribution and makeup of the accepting frame reveal its role as a powerful counter-narrative within euthanasia discourse. The accepting body frame reshapes the conversation around imminent death—not as a threat to be avoided, but as a natural part of human existence to be embraced. Instead of highlighting biomedical decline or loss of dignity, accepting narratives focus on the quality of remaining time, nurturing relationships, and exploring the spiritual or philosophical aspects of dying. In doing so, this frame

challenges a fundamental assumption in euthanasia debates: that suffering is inherently meaningless and that technological control over death is the ultimate ethical goal.

In Portuguese narratives of the accepting frame, spiritual and philosophical language prominently features, with palliative care articulated as a relational practice grounded in human connection—what we might call a practice of presence. The account attributed to Martins (2020) exemplifies this reorientation: "I'm afraid of feeling that pain again, but I never thought about why I was going through that suffering. Even though I'm young, I've already experienced something. It's worse with children. It's happened; I just must live as best I can". Another Portuguese example documents medical acceptance of the patient's resistance to sedation: "As he was in atrocious suffering, we proposed palliative sedation. . . He refused to sleep. . . When we gave him the opportunity to be anaesthetised, without suffering, he began to fight against it. . . Our animal instinct is powerful" (Faria, 2020).

In UK narratives of the accepting frame, the emphasis shifts toward pragmatic framing of choice and relational responsibility. The statement "I chose to keep fighting to live. Advocating for assisted dying in Colorado is about creating that choice for others: not a have to, not a must do" (Oksman, 2016)—illustrates how these accounts foreground individual autonomy and pluralism rather than collective spiritual meaning-making. This rhetorical approach performs vital analytical work. By distinguishing personal acceptance (choosing to continue living) from political advocacy (supporting others' autonomous decisions), the speaker bridges two seemingly conflicting positions—personal acceptance and public pluralism. Another UK narrative exemplifies relational endurance. A woman describes her mother's choice to continue despite extreme suffering:

> "She was clinging by the fingernails, as long as could," says Walton. "The tumours became so large in her bones that they fractured—they actually splintered—she had a broken left arm. We knew that would happen, she knew that would happen, but she just didn't want to leave her little fella" (Black, 2022).

What fundamentally distinguishes the accepting body frame from all others is not its presence in particular national contexts but its reorientation of suffering itself. While the dependent, shameful, and temporal frames all position suffering as the primary analytical problem—demanding either autonomy, dignity restoration, or temporal control—the accepting frame reconceptualises suffering as potentially generative. It proposes that not every instance of bodily decline necessitates technological intervention; rather, that acceptance, presence, and enhanced relational engagement can be observed as ethically valid and existentially responsive to the reality of mortality. This represents a departure from the problem-saturated framing that typically dominates both euthanasia advocacy and bioethical discourse more broadly. By introducing the accepting frame, we reveal a way of facing death that moves beyond the false choice of either battling against it or rushing it—one that embraces the reality of our mortality while opening space to discover meaning in the time we still have.

This frame places greater emphasis on existential and relational values rather than on instrumental control. It recognises that we must experience and actively engage with suffering, rather than merely solve it as a problem. The ethical foundation shifts from

autonomy (dependent), dignity (shameful), or medical truth (symptomatic) to presence and meaning-making. Narratives construct acceptance not as passive resignation but as active engagement with mortality's reality. This frame uniquely suggests that psychological and spiritual resources—meaning, connection, presence—may constitute legitimate responses to end of life suffering, challenging the implicit claim in other frames that only intervention (euthanasia) or suppression (sedation) are ethically adequate responses.

Conclusion

The aim of this study was to answer the question of how the dying body and the respective organ dysfunction in the terminal and end of life stages are framed in Portuguese and British news media stories on euthanasia. To this end, we relied on the seminal work of Street and Kissane (2001), who mapped the frames on the dying body at the end of life in the experiences of seven euthanasia deaths in Australia. Like them, it was identified that the stories framed the body as dependent, shameful, symptomatic, and temporal. The main novelty of this study is the emergence of a new frame: the accepting body. While in the study of Street and Kissane (2001) the frames were often narrated by the ill person, here family members and other sources of information—such as readers, columnists, doctors, nurses, and others—frame family relationships and present individuals and their families as autonomous persons who are aware of their decisions (Birenbaum-Carmeli et al., 2006).

Journalistic practices that integrate various frames in one story, alongside vivid depictions of suffering and personal testimonies, create a communicative environment that immerses readers in the intimate realities of the dying process. This layered, affective narrative style may reduce emotional distance and make it harder for readers to dissociate or suppress their emotional reactions. The prevalence of the description of the agony phase suggests an evolving social reality of public death in news media—one characterised by the hegemonic values of suffering and the politics of mercy (Sumiala, 2022). Whereas death was historically sequestered from public view, relegated to private spaces and institutional settings (Ariès, 1974), contemporary journalistic practices increasingly render the dying body visible, detailed, and emotionally proximate. This shift reflects broader transformations in media culture: from sanitised, euphemistic coverage to graphic, embodied portrayals of terminal suffering. Such news coverage contributes to the construction of collective imaginaries centred on aversion to suffering and bodily decomposition in the terminal phase and at end of life (Costa et al., 2026b).

Our findings should be interpreted within specific methodological constraints. First, our analysis is restricted to news narratives from major mainstream outlets in Portugal and the UK; future research would benefit from examining whether these frames manifest differently across digital media, tabloid coverage, or alternative news sources. Second, by focusing on textual and argumentative structures mobilised around organic dysfunction in terminal illness, we have necessarily excluded other discursive domains—such as policy documents, clinical guidelines, or patient advocacy materials—that may deploy alternative framings of end of life care. Future investigations could extend this analytical framework to these additional sites of euthanasia discourse, potentially revealing how frames circulate across different institutional contexts and audiences.

Despite its limitations, this study offers several important contributions for future research and practice. Firstly, it presents a comparative and culturally situated perspective that is often absent from current literature. Secondly, the results have practical relevance for different sectors. In healthcare, they can support the development of communication training for professionals dealing with end of life conversations. They also underscore the significance of ethically responsible reporting by journalists to prevent clichéd frames of suffering and disability. Additionally, they can serve as a basis for the development of regulatory frameworks that consider cultural sensitivities and the communicative aspects. Finally, the study also creates opportunities for further interdisciplinary research in communication, medicine and ethics, promoting a public discourse that recognises the vulnerability of the body and the sociocultural dimensions of death.

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Consent to participate

We used public online content.

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Data availability statement

The original data presented in the study are openly available at: The research data is available here: https://doi.org/10.17605/OSF.IO/TMY2.

Note

1 The authors have translated all quotations from Portuguese news stories into British English. They present direct quotations from English-language publications in their original form.

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