The right to die or the right to kill?
The argument against euthanasia

By Karen Hitchcock

Celebrity is our religion. Celebrities are our gurus, teaching us what to wear, what to buy, how to look and, now, what to think. They front campaigns for human rights and animal rights; they advocate for babies in war-torn countries. Now we even have the celebrity endorsement of euthanasia. Apparently Andrew Denton is an expert after eight months of research – less time than it takes to get a sommelier diploma from TAFE. Eight months, he repeats, as if this is extraordinary, as if this country is not full of people on both sides of the debate who have spent decades seriously considering the complex issues around euthanasia.

We’re both appearing on a TV show, for what he tells me backstage will be a “friendly discussion”. “I’m very nervous,” he says to me, the one with the dry mouth and sweaty palms, graciously adding, “I think you write like a dream.” On air, Denton declares that it’s time doctors started listening to their patients, all the while interrupting, dismissing and undercutting questions from the audience in a tone so patronising it would get a junior doctor hauled over the coals. I’m thinking, “Are we not allowed to countenance any doubts about euthanasia? Has it become a faith?”

It is time for us to discuss death, Denton says. “It’s time.” He looks straight into the camera, like a prime minister reducing complex issues to slogans. Apparently, legalising euthanasia will enable this discussion. In fact, the conversation has begun, though mostly in forums with less fanfare.

Euthanasia makes terrific TV. We hear compelling stories of torturous suffering
that make us ache for a way to help people out of their misery. But is death the only solution? And isn’t there something strange about the argument that we should give all these apparently deaf – if not entirely blockheaded – doctors a licence to kill?

“Euthanasia” is a word for the act of killing, as is “physician-assisted suicide”. Language is important in shaping thought, so we should call it what it is. If I write a prescription, I carry the responsibility when the drug is swallowed; that’s the deal with medicine. Otherwise, all drugs may as well be available over the counter. California will likely start executing prisoners again, having found single drugs that will ensure a “humane and dignified death” – even something as horrific as an execution can be reframed as an act bestowing dignity. Euthanasia advocates wield powerful yet slippery words: “assisted suicide” is promoted as a way to “control” one’s death, and guarantee “dignity”. This debate has fallen into euphemism. The right to kill has been reframed as a right to die. A power bestowed on doctors by the state has been reframed as an expansion of a layperson’s rights. I have been criticised for using the word “kill”, but if the real act is so offensive we should stop advocating that doctors do it.

Death is both everywhere and hidden in our culture. Children witness countless violent deaths on the screen before they hit high school, yet they’ve usually never seen an old person die up close. We have a disinfected expectation of what it is for a human body to die. A natural death may be instantaneous – a hand to the chest, a look of shock, followed by collapse – or it may be slow: the 95-year-old’s gradual refusal of food and drink as her organs enter quietude. What is the point of forcing families to sit around a bed for a few days watching their unconscious loved one “starve and dehydrate to death”? There is no obvious point. But to kill an unconscious dying person relieves only the suffering of the family. The dying person feels neither hunger nor thirst. Despite the rattling chest they are asleep. They will neither remember nor reminisce about these two or three days, because they will no longer exist.

It is true that patients may suffer avoidable pain due to a lack of palliative care services and poor education of clinical staff. If patients are dying with uncontrolled pain because clinical staff are scared to give “too much” morphine in case they are “charged with murder”, then there is a need to clarify the law around the principle of double effect: that sometimes the doses of drugs needed to control symptoms at the end of life will secondarily lead to a hastening of death. Spurned by Denton et al. as “slow euthanasia”, the principle is based on a simple edict that is the bedrock of medicine: a doctor treats symptoms, not life. Life is never the disease. And death is never the cure.

Many of the horror stories are the result of grief-stricken family members unprepared for, poorly communicated to and given no bereavement counselling after the death of their loved one. They are the ones left with the memories of good or bad deaths, and their memories are determined by their interpretation of the events, their definition of indignity, the hospital’s practices, and their relationship with the person who died. These are complex issues and will not be untangled by a clean kill.

Over the 12 years that I have worked as a doctor in large public hospitals, I have cared for hundreds of dying patients. No one has ever died screaming or begging for me to kill them. Patients have told me they want to die. My response to this is “Tell me why.” It is rarely because of
pain, but it is often because of despair, loneliness, grief, the feeling of worthlessness, meaninglessness or being a burden. I have never seen a dying patient whose physical suffering was untreatable. The combination of morphine and midazolam is extremely powerful; it can be administered and titrated up very quickly. Barbiturates can render one unconscious in minutes. Palliative care practices have come a long way in the past decade.

Studies repeatedly show that the desire to hasten death for those with a terminal illness comes principally from a feeling of hopelessness. We must listen to and attempt to address this and other fears. Knowing one is dying can be excruciating: the terror of non-existence. For thousands of well-educated, affluent people in vocal advocacy groups, a euthanasia drug like Nembutal is the sole way to wrest control of the only part of their life they may not fully control.

The simplistic understanding of the human subject as a wholly autonomous individual is based on an ideology that dovetails with our other current dominant ideology: the free market. In the lived world, both mostly benefit the privileged.

When we’re regarded as nothing more than free agents in a free market, needing care and assistance becomes an indignity. The act of caring for someone is viewed as a cost rather than a mutually enriching experience. We place people in nursing homes, which accelerate cognitive and physical decline – leave in their cataracts, leave out their teeth and hearing aids, trap them in front of a TV with a tea-towel for a bib, and avoid touching them unless absolutely necessary. And then we find them disgusting. Our horror at the thought of requiring assistance or care has a huge impact on those who do. You’re all better off dead, we’re saying, rather than collectively trying to improve their lot. It has always surprised me that progressive political parties in Western nations are the loudest advocates of euthanasia. I thought the basis of progressive politics was the conviction that many personal “rights” (to bear arms, to burn fossil fuels, to take home one’s entire pay cheque) were rightly compromised for the benefit of society as a whole. With the issue of death it’s as if we are suddenly just a collection of individuals who happen to be located on the same block of dirt.

If death becomes an option in the face of debility, then debility is turned into a lifestyle choice. Lifestyle choices are the responsibility of the individual. Our social responsibility is dissolved.

Despite our country’s vast collective wealth, we hear the constant cry that our health and welfare systems are unsustainable: resources are heavily rationed, there is a dearth of funding for palliative care and clinician education about it. Care for the elderly and disabled is handed out stingily and begrudgingly because people are economic units who can only be individually productive or not.

We may revere autonomy and the sanctity of free will, but people’s decisions are influenced by circumstance, their peer group and societal expectations. Formal consent is no guarantee of a decision freely taken. And importantly, patients’ decisions fluctuate over time; once you are dead, though, you cannot change your mind.

What is “unbearable suffering”? How should we as a society respond to it? What does it mean for our core practice of medicine if we no longer seek to help people for whom life has become so painful they want to exit, but instead assist them to die? In Belgium, death is now a valid treatment for “incurable”
depression. Some call this brave. You need a second opinion! As if that is some sort of safeguard in the face of state-sanctioned killing. Not so long ago, lobotomy was the treatment of choice. You needed a second opinion for that too. Doctors can be as crazy, unwise, mistaken and misguided as anyone. How should we triage people into suicide assistance and suicide prevention queues? Only 6% of psychiatrists in Oregon say they can confidently conclude that a psychiatric illness is not affecting a patient's request to be killed. Should the likes of those 6% be the ones to decide? It wouldn't take long for health insurance companies to assemble them into a list.

Life expectancy is difficult to predict, and the term “suffering” encompasses a galaxy of sensations and emotions. The degree of suffering is always subjective. The human animal has an extraordinary capacity to find meaning in and even enjoy a life marked by limited function and debility – particularly if care is freely offered. Chronic pain clinics are full of patients who don’t have terminal illnesses. They are experiencing pain they find insufferable, often despite no organic pathology, often in the context of psychosocial chaos. Should these people be offered death? Or should we instead continue to provide psychological and social support, and to research neuroplastic ways to help these people find peace? Why bother, if we decide death is the treatment?

There are calls to include “existential suffering” – part of the price we pay for life – as an indication for death. Existential suffering is felt by most people at some point, certainly most people with a serious disease, and can be a source of wisdom.

To refuse treatment is a right. To demand care is a right. It is not illegal to commit suicide – though we try to prevent its enactment. To kill or to ask to be killed is not a moral or legal right. Euthanasia is a cheap solution to the difficult and complex problem of caring for those dependent, suffering and dying. We search for a clear line beyond which we should agree: Yes, your life is not worth living. The line is always arbitrary. And it is a cliff, not a line.

Any attempt to make death easy will inevitably expose those in the community who are vulnerable to untimely deaths, to feeling worthless and burdensome. No panel of doctors or booklet of rules, no ream of checks and balances, can prevent this invisible coercion based on new social norms. It is clinicians on the front line who see this invisible coercion in action: patients apologising for taking up beds, for being a burden, for finding themselves disgusting and so wishing they could die.

I can understand why killing might be framed as a humane response to your diminished function, physical suffering and mental anguish. But our responsibility is to help make your life bearable. I hope for a society with the values and the resources to allow us to say, Don’t be scared. We will attend to you, ease your pain, witness your anguish. No, we will not kill you.