The Importance of Stories in the Euthanasia Debate

The risks and harms to vulnerable people outweigh any possible benefits

Margaret Somerville

The pro-euthanasia case is compact and quick and easy to make: It focuses on a terminally ill, seriously suffering, competent adult who gives informed consent to euthanasia and bases its claims to prevail on the obligation to respect that person's right to autonomy and self-determination and dignity.

The case against euthanasia is more complex and time-consuming to establish. It requires placing euthanasia in a much wider context that takes into account, among many other considerations, what its impact would be, not only in the present, but also in the future, and what protection of vulnerable people and society demands.

Euthanasia involves a clash of two important values: respect for individual autonomy and respect for life. Pro euthanasia advocates give priority to autonomy; anti-euthanasia proponents to respect for life.

Respect for life is not just a religious value as pro-euthanasia advocates argue. All societies in which reasonable people would want to live must uphold respect for life and at two levels: respect for every individual human life and respect for life in society in general. Even if legalising euthanasia were viewed as not contravening the former, it seriously harms the latter.

Both the pro- and anti- euthanasia sides in the euthanasia debate are trying to persuade the public to affirm their stance. So how are they presenting their cases to the public?

We form and support or reject the shared values on which we found our society, in part, by creating stories that we tell each other and buy into in order to create the glue that binds us together as a community.

The pro-euthanasia case relies on "bad natural death" stories – stories of the extreme suffering of some terminally ill people who die a natural death – and characterises and promotes euthanasia as an essential-to-provide kindness and its prohibition as cruelty.

Anti-euthanasia advocates often counter these stories with "good natural death" ones of people dying naturally and peacefully, in the presence of those they love, feeling that they have had a completed life. ("Good death" stories do not assume that death can be good, but rather that the process of dying a natural death can be "good" or "bad" and that we can to a large extent influence which of these it is by the physical, psychological and spiritual care that we provide to the dying person.)

But there are also some "bad euthanasia death" stories which support arguments against legalising euthanasia. One, by journalist Guilia Crouch, was posted on the website of the *Daily Mail*. It gives an account of the following facts:

Last month, a Dutch Regional Euthanasia Review Committee reported on a case brought before it. The woman patient had dementia. A woman doctor put a sedative in her coffee as a prelude to euthanising her without telling her of the sedative or her plans for euthanasia, the doctor said "because she did not want to cause her [patient] extra distress". In deciding to euthanise her patient, the doctor was relying on a phrase in the patient's declaration in her will that "when I myself find it the right time" she could consider euthanasia.

While being injected with the lethal drug, the woman woke up. She struggled and the only way the doctor could continue with the injection was by asking the woman's family to help to restrain her, while she continued with the injection. The woman's case notes recorded that she had said several times in the previous days, "I don't want to die".

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The review committee concluded that the doctor "had crossed the line" by secretly giving the sedative and not stopping the injection when the woman resisted and had too broadly interpreted the woman's declaration, but that the doctor had acted in "good faith" and should not be punished.

However, the chair of the review committee wants the case brought to court to create a precedent to enable other doctors to lethally inject people with dementia, without fear of legal repercussions.

So what can we learn from this story?

Even if we believe that euthanasia is not inherently wrong, its risks and harms to vulnerable people – those with disabilities, the elderly and the fragile – outweigh any benefits.

I have written previously about the Australian Law Reform Commission's research on elder abuse. Between 4 and 14 percent of old people are abused, most often by a close relative. It's hard to imagine a more extreme form of abuse than helping a doctor to euthanise an elderly relative by restraining the "loved one" who doesn't want to die.

The Commission was concerned in particular about "early inheritance syndrome", where a person, usually a child of the old person, obtains a power of attorney and uses the financial assets of their parent for themselves.

Many people worry about the cost of residential care for their elderly relatives and heirs see "their" inheritance, to which they feel entitled, dissipating. Many old people say they would rather be dead than go into a nursing home. Imagine adding euthanasia to this situation – it would certainly be a lethal cocktail.

Euthanasia is, what is called in ethics, a moral hazard – that is, it opens up possibilities of breaches of ethics, such as I've just described.

A response might be that the moral hazard risk of euthanasia can be avoided if only assisted suicide is legalised. But it, too, is a moral hazard. Research shows that high on the list of reasons people want to die is that they feel that they are a burden on loved ones and there is an ever present danger of coercion.

There is also a broader moral hazard from assisted suicide: the general suicide rate has increased in every jurisdiction that has legalised assisted suicide. This is not surprising. State-sanctioned assisted suicide endorses suicide as an appropriate response to suffering and suicide is contagious. Suicide is also the leading cause of death in young adults. This is a serious and major public health concern, which legalising assisted suicide would only magnify.

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How could this Dutch doctor have done what she did? That same question has been pondered over and over again in relation to the Nazi doctors.

It's a result of a process of incremental desensitisation of the doctor to what is involved: namely, killing her patient.

This desensitisation results from multiple factors. Placing the "white coat" of medicine on euthanasia carries with it messages of the ethical validity of euthanasia and its kindness. The language used to describe euthanasia is massaged and euphemised. The doctor is blinded by a conviction that this is best for the patient and she's only doing good for her. The doctor has no conscious recognition that this is not medical treatment and that she is acting contrary to medicine's healing mandate and beyond the proper goals of medicine.

The doctor's equanimity may, however, be only on the surface. At a deeper level of the psyche, carrying out euthanasia may have harmful impact on healthcare professionals. Doctors in the Netherlands and Canada are opting out because they are suffering mental trauma, including PTSD, from providing it. Some Canadian doctors who placed their names on a list of doctors willing to provide euthanasia withdrew their names after undertaking their first case saying it was too traumatic for them and they never wanted to do it again.

This is not surprising: Doctors are trained to heal and save life wherever possible, not to intentionally take life. And all mentally healthy human beings have a powerful instinct against killing another human being.

We must never ignore the heart wrenching pleas of both those who are suffering and those who love them and want the loved one's suffering ended. But we must kill the pain and suffering, not the person with the pain and suffering.

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