EOLC Sub 683
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Submission on "Euthanasia" or End of Life Care

Qualifications:

Registered General Nurse 1965 to present

Registered Midwife 1967 to 2016

Registered Child Health Nurse 1969, not current.

Member Australian Nursing (and Midwifery) Federation 1966 to present

Councillor, Executive member Vice President, President 1982 to 2002, Federal Vice President ANMF 1994 to 2000

Member Nurses Board WA 1998 to 2000

Foundation Member and Life Member of WA Practice Nurses Association.

Former member of Community Nurses Association and Infection Control Association

Former Secretary Bioethics Nurses Association.

Worked in Midwifery and General nursing continuously for over 50 years, in public and private sectors and in community;

Currently employed in a public hospital on an acute medical ward with a high number of elderly, chronically ill patients, as well as younger chronically ill patients with history of drug abuse and or alcohol abuse.

More than 50 years continuous experience as a nurse in various settings.

Clarification of Terms:

Euthanasia is a "made up" term; in the past one talked about "putting down" their sick/injured animals. As people became more closely attached to their pets, often treating them as their children, they invented the verb "euthanase" which still meant to deliberately end the life of that animal/pet. These days when people find it hard to face the hard facts of life, one very rarely hears of an animal being "put down"; they are "euthanased".

Applied to a human being, the action can only mean the ending of a life, and as the law stands at present the action can only mean, at the least, manslaughter, or murder.

Suicide is the process in which a person takes their own life deliberately.

Assisted suicide is another euphemistic term to describe the process in which a second person "assists" the first person to take their own life.

Assisted Dying" is nothing less than assisted suicide in which a person other than the putative patient is required to assist with an action which will deliberately terminate the life of the sufferer.

Further Clarification:

Unfortunately there is a great deal of misunderstanding surrounding the care of people with chronic or end of life conditions and this has resulted in, on the one hand, a demand for an end to suffering by terminating the life of the sufferer, and, on the other hand, a reluctance to either stop active but burdensome care which cannot cure the patient, or to administer medication to alleviate the symptoms of the condition but which may, as a side effect , shorten the life of the sufferer.

Cease active treatment:

This means acknowledging that there is little hope of actually "curing" the person, and also recognizing that the treatment may have become burdensome to the patient. This would include treatment of cancer when it is clear that the patient is not going to be cured and the treatment may be causing nausea, vomiting, pain and distress.

Another instance may be the use of intravenous antibiotics in the care of an elderly patient with chronic infection and poor veins; often the need

for regular re cannulation (inserting a needle into the vein) becomes something the patient dreads, the procedure may often be unsuccessful and it causes the patient added suffering.

At this point a patient will often say "let me die" or "put me down", but if the burdensome treatment is stopped and comfort measures are applied, the patient will be comfortable and no longer wish to die.

In other words, they just wanted the suffering to stop.

End of life Care

End of Life Care and Palliative Care are not synonymous although palliative care is given to the same end in both end of life care, and in the care of those with chronic conditions.

In End of Life Care there is a recognition that life is drawing to a close; the aim is to keep the patient as comfortable and undistressed as possible and to support significant others so that they can get the most comfort from the short time they have left with their loved one.

In end of life care the intention is not to end the life before nature takes its course, but to use all means to ensure that as far as possible the patient is pain free, undistressed and comfortable.

Palliative Care

Palliative Care is not just administered at the end of life. It is used to alleviate the suffering caused by the patient's condition at any time, but it has a particular benefit when active treatment has ceased and control and / or alleviation of symptoms is the goal so that the patient may be as comfortable and functional as possible.

Palliative care can sometimes give quality of life over months and even years. It is a change of focus, which may allow the use of medication which in other circumstances would be used with caution.

For instance, in palliative care addiction is not a major consideration – relief of pain is, but in other circumstances one has to consider whether one is adding to the patient's burden by letting them become addicted to a substance which should be withdrawn when the patient returns to wellness.

A case in point is the use of morphine and its derivatives. Morphine is considered to be a respiratory depressant, but in the case of end stage chronic airways disease, or late stage heart failure Morphine is of great benefit in small doses, in that it allays anxiety and pain, encourages deeper and more effective respiration and thus gives the patient a better quality of life. In this instance, addiction is not a major consideration.

Reasons Why a Person Might Seek To End Their Life

There are many and varied reasons why a person may decide that their life no longer has value to them to the point where they would wish to end it.

It is very important to discover what these reasons are and seek to address them, so that the person has a good quality of life for as long as their life lasts.

Some of these reasons are founded on a misapprehension, such as fear of going into an Aged Care facility, and some on a real possibility of pain, loss of independence etc without understanding what can be done to assist them to overcome these burdens.

I will try to deal with a number of these reasons concisely but would welcome the opportunity to speak about this to the Committee.

Loss of Independence. Many people become very anxious about not being able to look after themselves and becoming "a burden" on others.

This attitude is going to become more prevalent with all the media advertisements urging older people to utilize this product or that to avoid becoming a burden on their children. Note the advertisements, for instance, for Funeral Insurance. Personally I re iterate to my patients that it is my privilege to care for them and to serve them and that deserve such care at the end of their lives, just as they gave care to their families and others in need.

Fear of going into Aged Care: There are some very good care facilities and some not so good but there is a common perception among the elderly that to go into care is a bad thing and they usually cannot see many positive aspects. Often they will continue to live lonely lives with great difficulty in their own homes, rather than consider going into care. For many to spend their last years/days in a good Aged Care Facility brings a new quality of life for them. For instance I have known bedridden patients who had a very good quality of life in an Aged Care Facility through a love of music, reading, and relationships developed with the staff and visitors

Fear of pain. Many people fear that they will be left in unremitting pain ; good palliative care can do much to address this fear

Fear of Dying. Strangely enough, many people face a fear of death by wanting it to be over as quickly as possible. Sometimes when a patient decides that the treatment of their end-stage condition has become burdensome, they will ask for the treatment to cease, and will ask, in the next breath, that the medical/nursing staff will end it for them.

I have found from experience that if their fears are addressed in a respectful and caring manner they will feel able to accept palliative measures and make the most of the time left to them. Often they come to see their lives as having more value to others than they had thought.

Fear of a Loss of Dignity:

The word "dignity" has been misused in recent times and it is overused and misused by the protagonists of assisted dying as in "Dying With Dignity". In over 50 years of nursing experience I cannot say I ever saw any person die with a lack of dignity.

On the contrary I have seen a number of patients die with more dignity than they had when they were living their chosen lifestyle eg: alcoholics.

Dignity is not in any way related to whether the person has control over their bladder and bowels and the fact that a person has lost control over those functions does not mean they have less dignity or that their life is less valuable than that of another; it is certainly not a reason to terminate their life regardless of euphemistic terms.

Pressure from family members:

This is not unusual and it is usually very subtle. The person comes to see themselves as a burden on family in terms of physical incapacity and financial costs which may include the idea that they should not "spend the children's inheritance "on prolonged care.

There is also, often, as a symptom of modern life, a feeling on the part of family "to get it over with" I have cared for patients who were dying and their relatives have kept asking – in front of the patient , "How long is this likely to take? Can you hurry it up?"

Reasons Mitigating against "Assisted Suicide/Euthanasia/Assisted Dying

Birth and death have a very profound spiritual aspect which cannot easily be put into words. As at a birth, when one feels a deep respect for the actual birth itself and the emergence of a little human being, so the effect, when present at a death, is similar; A sense that something has taken place that is not completely explainable, a sense of being in the presence of a Presence. There is also a sense that the dying person and that Presence are participants in something in which you are only a witness.

Caring for the sick and dying has an effect on the carer in that they usually learn compassion and tolerance. No matter what the circumstances of the patient are, even if it is perceived that they have contributed to their situation by their own actions eg: alcoholism, drug addiction etc, seeing their suffering softens judgements and makes a carer want to alleviate that suffering in what ever small ways might bring relief and comfort. This in turn gives the sufferer a sense of self worth and dignity.

Personally I have learned a great deal about forgiveness from caring for the dying. To see a person suffer is to prompt the thought that no matter how great the injury done to one, you would not wish such suffering on any person.

If we did not have suffering people to care for, how would we ever learn compassion? And if we "disposed" of them when the suffering was burdensome to them and to family and even to the carer, what would we be saying about the value of life and of individuals?

The dying period is a very important time often to both the patient and to the family. I have often seen relationships healed in that period.

One cannot always say how long a person may live after they have been deemed "terminal" or even palliative. I have seen "terminal" patients whose pain and other symptoms have been well relieved live another happy six months in their own homes.

It is time we stopped and had a good look at the contradictions in our thinking and actions.

We are shocked and horrified when a baby is ill treated and dies, but we are not in any way shocked at the thought of a perfect little human person being aborted because it is not wanted.

We are spending a large amount of money and running big campaigns and crying over the large number of suicides but we are planning to make it legal for certain people to either take their own life or be assisted to do so.

Who thinks they are qualified to make the distinction as to who is allowed to live and who is allowed (helped) to die? Who gave them that qualification?

Also not dealt with is the question of what pressure will be brought to bear on health care workers – doctors, nurses etc – to be the ones to assist in this process? In Victoria the abortion laws are such that it is an offence to decline to perform or assist at an abortion. Many valuable doctors and nurses have moved away from anything to do with gynaecology or obstetrics rather than be prosecuted for following their conscience and declining to do an abortion or refer a client on for one. Will we see an exodus of good doctors and nurses from palliative care?

Summary

Just because we do not have a religious belief does not mean that there is not a spiritual element in the whole of life and it is very obvious that there is a cosmic balance in nature and the earth. If we show a lack of respect for all human life, a culture of death will overtake us and we will not have any control over who dies when because there will be no real respect for life. It is nature to

fight for Life, why would Man, supposedly the highest form of Intelligent Life be so anxious to fight for Death?.

Finally:

To change the Law to allow for "Voluntary" euthanasia or "assisted" Suicide is fraught with hazards.

There is no way that sufficient safeguards can be written into a Bill to protect the vulnerable who would not voluntarily choose death over life, nor to protect those people who would choose not to assist in such activity.

Furthermore the Law may have great difficulty proving that murder in some instances is not actually euthanasia in any form, or vice versa.

Most people, in spite of the clamour for euthanasia, do not actually want to see the Law changed and especially the elderly. In forums in which this is discussed the elderly are always much relieved to hear what can be done in the way of palliative care, and they have an underlying fear that the Law will be changed to allow euthanasia; they have an apprehension in regard to going into Care or placing themselves under the care of a new practitioner if the Law is changed.

It is interesting to read of what various former statesmen have had to say on the subject, notably Paul Keating in the Weekend Australian.

Regardless of what other States do, Western Australia should not embrace this culture of death by changing the Law but should put more resources into alleviating the suffering of people regardless of age and mental capacity with good palliative care.

To:
Hon Nick Goiran MLC LLB BCom
Member for the South Metropolitan Region
Shadow Minister for Child Protection; Prevention of Family and Domestic Violence
Secretary to the State Parliamentary Liberal Party