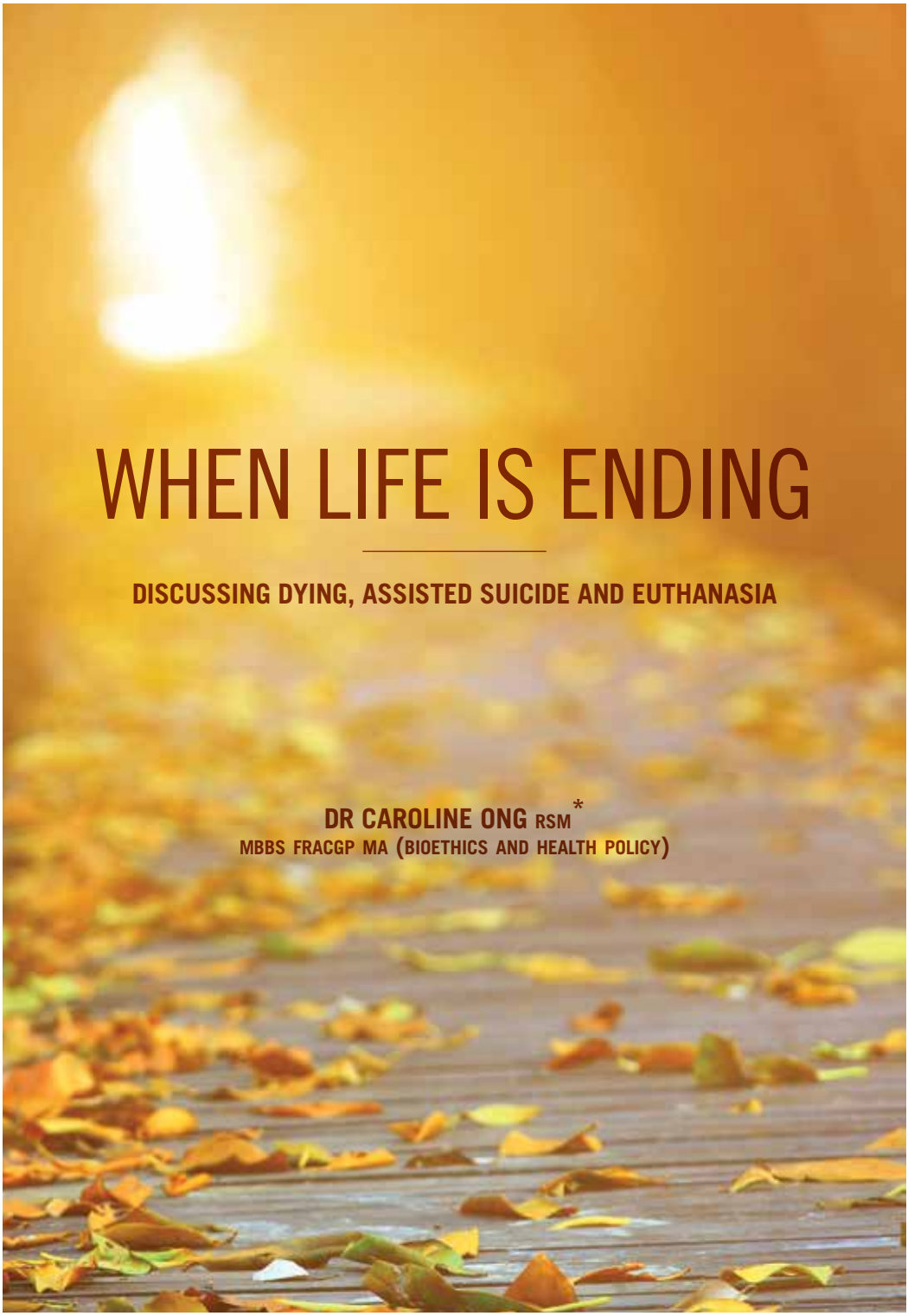

WHEN LIFE IS ENDING

DISCUSSING DYING, ASSISTED SUICIDE AND EUTHANASIA

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WHEN LIFE IS ENDING . . .

THE LAST PHASE OF LIFE – dying – *can* be one of the most precious parts of living life to the full. It *can* be the time to make amends, to do the things we want to and can do whilst we are alive. It can be the time to consider what we want to leave behind for others.

It can also be a lonely and vulnerable time, as friends and family continue to live busy lives and fear of the unknown grows. As our bodies age and, for some, diseases progress, this can bring pain and suffering.

Suffering happens when things are no longer what they should be, or have been, and so we experience pain – whether physically (in our bodies), mentally (in our thinking) or spiritually (in how we are with ourselves, each other and our relationship with God). It is natural to want to relieve this suffering and important to do what we can to ease or heal it.

Healing *can* happen when whatever is causing the suffering is either removed or controlled. Examples include curing the disease, having enough pain medication, forgiving and being reconciled when necessary, administering insulin for diabetes and counselling and/or medications for depression.

Healing *can* also happen when we feel someone cares for us and loves us, when we feel we belong and are not a burden or nuisance to others, or causing their pain. The disease, or feeling of loss of what was, may still be present or continue to progress, but the suffering *can* become more

bearable. For some people suffering *can* be seen to have meaning. For instance, some Christians sometimes see their suffering, offered up in love, as uniting them to Christ's suffering. Their suffering then becomes bearable and meaningful. However, no one should romanticize dying or death.

Health professionals, like doctors, nurses, physiotherapists, pastoral carers and counsellors, can help with healing. When we seek their help, we trust they will help us heal.

Palliative care health professionals specialise in caring for us both when the symptoms of illness cause us to suffer, and when our life is ending. With their training, they know the right medications to ease our pain and suffering. They can help us decide what is most important to us, including our relationships with loved ones, and they can help us to fulfil our hopes for this last part of life. Palliative care health professionals can help us understand what to expect when life is ending and ease our fear, and in particular our fear of loss of control. They can assist us in healing all parts of our lives that need healing before life draws to a close.

Advance care plans help us to express our values and indicate our wishes and likely choices of treatment or non-treatment. They are particularly helpful when we are unable to participate in decision making when life is ending.

General understandings about end of life care

- Every person's life has value. This is also known as the 'inherent dignity of the person'. There is no exception, no matter how reduced a person's life becomes.
- Death is part of life. For many, life is a gift from God and death a transition to eternal life.
- Life is relational. We all have a need to belong, to be loved and to love, especially when our life is ending.
- End of life care involves caring for the whole person – physical, mental and spiritual – as well as family, loved ones and carers.
- End of life care focusses on dying peacefully.
- End of life care assists in alleviating the person's fear and sense of loss of control by explaining what to expect during the final stages. Reliable and honest communication can help the dying person to reclaim their identity and ongoing meaning and purpose in life.
- End of life care involves impeccable pain and symptom management. This means the person receives enough medication to ease pain and become comfortable. Medication given in amounts needed to relieve pain does not cause death. Sometimes when pain relief medication is given, the person relaxes and dies.

Nevertheless, the intention is always to relieve the pain and distress – not to cause death – even if death unintentionally follows. In rare situations, when pain medications are not fully effective or if other symptoms like breathlessness are distressing to the person, doctors can sedate the person to sleep through the last part of their life. Again, the intention is to ease the pain and suffering of the person, not to cause death, even if the doctor can foresee that death may come sooner rather than later.

- There is no obligation for the dying person to receive life-prolonging treatment when the treatment does not cure the disease or offer other therapeutic benefits. Neither is there an obligation to provide such treatment.
- There is also no obligation to accept treatment when the burden of the treatment, that is the suffering that the treatment causes, is greater than its benefits. This also includes the burden of financial cost. What is burdensome to one person may not be for another person. It may also be different for the same person at different times during the dying process.
- Withdrawing (stopping treatment) or withholding (not giving) treatment when the burden of the treatment is greater than the hoped-for benefits is to allow the person to die naturally. Again, it is not intentionally causing death.
- When the dying person is unable to make the decision to withdraw or withhold treatment, the person making the decision on their behalf should consider what the dying person would have wanted, or would have refused, and not what the person making the decision wants. This is where an advance care plan can come into effect.

Inquiry into End of Life Choices

In June 2016, the Victorian Parliament's Legislative Council Legal and Social Issues Committee released its report on the Inquiry into End of Life Choices. The committee recognised the pressing need to improve palliative care services, both in terms of standards and accessibility, especially in regional and rural areas, aged care facilities and Indigenous communities. It made nearly 50 recommendations to the Victorian Parliament to improve end of life healthcare and raise awareness about end of life issues in our society.

The 49th recommendation is to make it lawful for doctors to intentionally end a person's life if the person asks for it because of unbearable suffering, knowing they will die soon. This can be done either by prescribing drugs for the person to end their own life (assisted suicide) or by intentionally ending the patient's life by administering drugs (euthanasia).

The 49th recommendation goes against what end of life care is all about.


“When a person’s life is ending, we have an opportunity to accompany them till they breathe their last breath. We can ease their pain and suffering through good palliative care. We can love and care for them in such a way that they know they are not a burden to others.”

What would it mean?

If legislation adopting the 49th recommendation is passed it could totally change society's understanding of the value of each person's life.

In legalising assisted suicide and euthanasia, we are saying that our society accepts that when life is ending and there is unbearable suffering, it is okay to end it prematurely, even though there may be much that can be done to relieve the suffering.

Our beliefs and the law tell us it is wrong to kill or even harm another person. In fact, the prohibition on killing is the cornerstone of the law: it protects all of us and allows us to live together in a safe society. When we say it is okay to assist another to end their own life because they are suffering, our commitment to this cornerstone falters and we undermine the fundamental protection of life.

If the 49th recommendation is passed, doctors entrusted with healing and saving lives from premature death would be asked to end lives. This would be an enormous pressure to place on the profession and potentially a source of great trauma.

The elderly and frail, and people with disabilities and other chronic conditions may feel pressured to prematurely end their lives. The guilty feeling of being a burden to others has been shown to cause some people to seek to end their lives. Staff who work in hospitals, hospices, nursing homes and other aged care facilities are aware of people who take advantage of their elderly parents by pressuring them to relinquish financial control. This law may well allow some relatives to take it further and pressure the elderly to end their lives before the time of natural death.

Conclusion

When a person's life is ending, we have an opportunity to accompany them till they breathe their last breath. We can ease their pain and suffering through good palliative care. We can love and care for them in such a way that they know they are not a burden to others.

When we can all accept that dying is the final part of living, when we can reassure the dying person they are still loved as they are, not just as they were, and that their life still has meaning, then dying can be peace-filled and precious.

Instead of providing the option to end life, we need to focus on the merits of end of life care and planning, and on making continuous improvements in these areas. There is much to be done to ensure that everyone in our community can die well.

Legalised euthanasia and giving assistance to suicide are not the answers.

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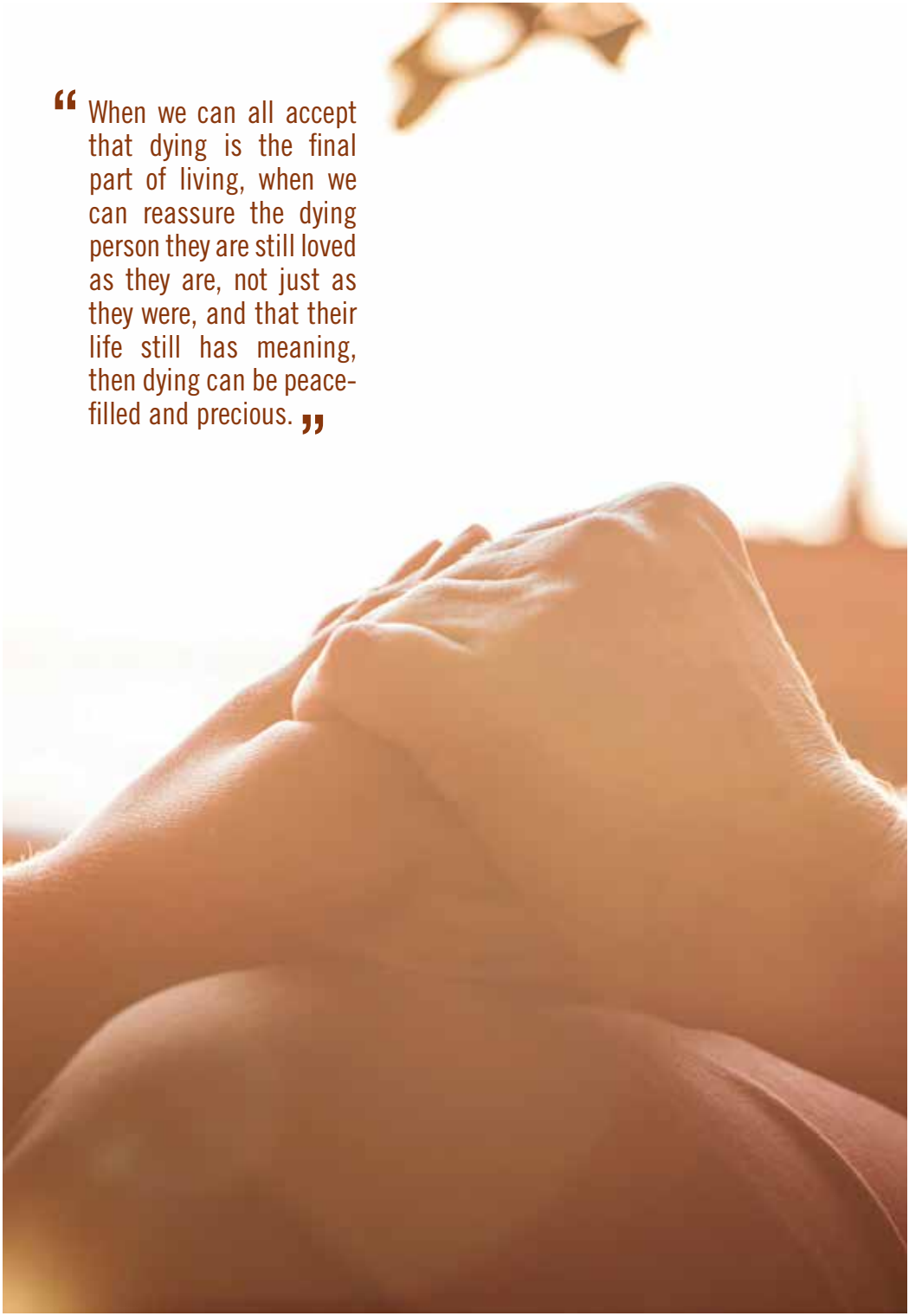

Some references and suggestions for further reading:

Congregation for the Doctrine of the Faith, *Declaration on Euthanasia – Jura et bona,* Holy See, (http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html)

John Paul II, *Evangelium Vitae,* Holy See, (http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html)

Victoria, Parliament of. "Inquiry into end of life choices." (2016)

Boudreau, J. D. and M. A. Somerville (2014). "Euthanasia and assisted suicide: a physician's and ethicist's perspectives." Medicolegal and Bioethics: 1. (https://www.fesemi.org/sites/default/files/documentos/bibliografia/euthanasia-and-assisted-suicide-ml-and-bioethics-2014.pdf)

Ong, Caroline (2014). *When life is Ending.* Chisholm Health Ethics Bulletin, 20(2): 5-8.

Good, P. D., et al. (2005). "Effects of opioids and sedatives on survival in an Australian inpatient palliative care population." Intern Med J 35(9): 512-517.

Hudson, P. L., et al. (2006). "Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review." Palliat Med 20(7): 693-701

Catholic Organisation for Life and Family (2005), *Euthanasia and Assisted Suicide Urgent Questions,* Life Matters. (http://www.chac.ca/resources/other_resources/euthanasia.pdf)

Fisher, A, (2016, Oct 15). Palliative care, not euthanasia: no need for a licence to kill. The Australian, (http://www.theaustralian.com.au/opinion/palliative-care-not-euthanasia-no-need-for-a-licence-to-kill/news-story/1d26fa5d27e9ad8324b6b7d81d7a7ee4)

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www.cam.org.au/euthanasia