Dr Margot Kerley
Standing Committee on Ageing
House of Representatives
Parliament House
CANBERRA ACT 2600

Dear Dr Kerley,

I write to express some concerns in relation to our increasingly ageing population.

There is a growing imbalance of population in Australia with a drop in fertility i.e. not enough young coming on to sustain the elderly in the years ahead.

Added to this, elderly Australians are living longer because of better diet and better health care and advances in medical science. It is pleasing to note the many Australians who even in their eighties, are still able to drive and travel and to engage in a number of interests.

Nonetheless, as sufficient people live longer, there needs to be adequate facilities for their care, such as nursing homes, special accommodation hostels and retirement homes.

Added to this, it is essential that auxiliary services are fully developed so that the life of an elderly person, especially one with no family carers, can be lived in comfort and ideally, without loneliness.

One reason that many of the elderly require more community help is that unlike earlier times, when daughters traditionally cared for ageing parents, many of those daughters are now part of the work force.

Another problem can be that children of elderly in their nineties can themselves be in need of care, as in many instances, they can be classified as being “elderly” also!

A prime concern of Right to Life Australia is the danger of denial of simple life saving treatment to elderly patients, as a way of hastening death. I speak here of an increasingly common practice of withdrawal of artificial nutrition and hydration, antibiotics or even in one case brought to my attention of withdrawal of insulin injections from an insulin dependent diabetic because she was suspected of having cancer! This was related to me by a nurse in a Canberra nursing home, who along with other nurses, refused to stop the insulin. The old lady in question was not a dying patient.

I have heard of many instances of elderly patients who have suffered a severe stroke, being denied nutrition and hydration as a means of hastening death.

This has been described to me by an experienced trained nurse who works in a well run nursing home in regional New South Wales as “not prolonging life.” It certainly won’t prolong life and will ensure death whether death is imminent or not.

Undoubtedly, this practice of procuring death by omission of warranted treatment, will help relieve pressure on nursing home beds!

Administering of nutrition and hydration is not, of itself, medical treatment. It has no curative powers. It is a means of ensuring patient comfort and denial of it, unless death is imminent, means an agonising death.

Administering of antibiotics is not difficult or expensive and should not be denied an elderly patient who has not a terminal condition, but rather has fractured a hip or is injured after a bad fall etc.

There is alarm in some medical circles in the U.K. over the recently released recommendations of the General Medical Council’s new “Good Practice Framework which advocates withdrawal of nutrition and hydration from patients not imminently dying.

To quote Dr John Keet F.R.C.P., a U.K. consultant physician – “If this practice does continue in our hospitals, it is deplorable. It is not a pleasant phenomenon to witness for staff, relatives and all concerned. One sees a patient in discomfort. Sometimes patients perk up inexplicably during the course of being dehydrated and starved, and because one has embarked on this policy it is very difficult to reverse it.”

Clearly the increasing strain on health care budgets, added to the ageing of our population will bring into question the wisdom and value of administering simple life saving treatment to elderly patients not immediately dying, but who will die prematurely as a result, if it is denied.

During the time of the Keating government the Economic Planning Advisory Committee released a booklet which addressed growing concern over the ageing of Australia’s population. One recommendation was to encourage elderly people to sign “living wills” and refusal of treatment certificates.

The group in the community whose lives would be most at risk should active euthanasia be legalised, would undoubtedly be the elderly many of whom would seek a premature death because of depression (life not worth living) or loneliness and debilitation not necessarily because of a terminal illness.

Then too many of the elderly would feel they had a duty to die to get out of the way and cease being a burden to their families.

Results of a survey by a U.K. socialogist and epideminologist of 2000 recently bereaved relatives, published in the British Medical Journal in October 1994, revealed that less than 4% of the deceased requested euthanasia. The main reason for this was fear of being a burden to their families.

Given the enormously valuable contribution made by the aged to the life and development of Australia it is the very least we can do to ensure that their later years be spent in comfort and that their lives be valued until such time as natural death occurs.