Alice Glover

8/8/02

Committee Secretary, Dr Margot Kerley
Standing Committee on Ageing
House of Representatives
Parliament House
Canberra ACT 2600

Dear Dr Kerley

I am writing in reference to the inquiry by the House of Representatives Committee on Ageing, investigating issues such as aged care, adequacy of; retirement incomes, workforce participation, housing and health.

My expertise and experience, and therefore the content of my submission, is limited to the fields of Aged Care and Health.

1. Change in Attitudes and Expectations among Health Professionals, especially in relation to Nursing Homes and Residential Care.

l am a General Medical Practitioner who has been working for over 13 years in a large, long-established, group practice in Brunswick in inner urban Melbourne. A large proportion of our practice comprises people of widely differing socioeconomic and ethnic groups, whose only common denominator is that they are in an age range above 70 years.

When I was a Resident Medical Officer in various hospitals in the 1970's, there was an unwritten rule that we' did not send a patient over 70-75 years to the Coronary or Intensive Care Unit after they had suffered a myocardial infarct or similar major medical or surgical event It was presumed that it would be inappropriate for such a patient to occupy an intensive Care bed when they had reached their 'biblical' life span, and that they should receive good medical care in an ordinary ward but without major intervention to prolong life. Understandably medical advances have made this unspoken age-limit inappropriate for many who now. have a good. quality of life well into their 70's and 80's.

However, I now visit Nursing Homes where residents aged in their 80's and 90's with a significant respiratory infection or a presumed deep vein thrombosis, are transferred to an acute hospital Emergency Department for definitive diagnosis and potentially curative treatment. These same residents are suffering chronic debilitating cognitive

or physical illnesses which are the reason for their being admitted to the Nursing Home in the first place. The reason for their emergency transfer is usually that the nursing staff and/or visiting medical officer is afraid of the medicolegal consequences and family disapproval if active intervention to prolong life is not undertaken. Prolonging biological life seems to have become the goal of medical and nursing management.

This situation is not satisfactory for either the Nursing Home residents or health care providers, and it is certainly a misuse of the overall health budget. It has worsened significantly since the unfavourable publicity given to Nursing Homes after the “kerosene bath” incident in Victoria and the associated political and media publicity.

Another consequence of that unfortunate episode has been the massive increase in unproductive paperwork being undertaken by highly qualified nursing staff. The morale in all the Nursing Homes I visit, has still not recovered, and the amount of "hands on" nursing carried out by the senior, more qualified, nurses has greatly diminished. It seems to me that this is precisely the opposite of what the Minister, policy makers, and health administrators wanted to achieve. It certainly has worked to the detriment of the residents in the Homes.

Recommendations

1 That part of the standard information supplied to residents and family members at the time of assessment or at least admission to Nursing Homes is a statement that the aim of care in the residential facility is to maintain the physical, mental and social well-being of the residents through good nursing care, and that major medical or surgical procedures requiring, hospital admission would not normally be appropriate.

2. That wherever possible, young, physically disabled, people requiring high dependency care but where the considerations described in [1] may be inappropriate, be housed in separate facilities

2. Need for Change in Awareness of, Legal and Ethical Issues in the Community and Health Professionals.

There is a wish volunteered by almost all patients whom I meet in the course of my medical practice, regardless of their intellectual or social background, that they want to have control of their Fife, and implicitly, their end of life. Most have not thought through the practicalities of how this can be achieved for themselves or their family. On the contrary, there seems to be a view that unnecessary suffering or prolongation of life is due to some medicolegal requirement that if there is something which can be done to maintain life, then it has to be done.

I have the impression that the overwhelming majority of my patients support the concept of being able to choose to end their life if they find the suffering intolerable. This is expressed m many ways, such as comments "I'm not going to let anyone keep me alive like that","You'd help me wouldn't you, if it came to the crunch"; “I’m just

going to end it all my way, not be put in a bloody home" There is an obvious oversimplification and took of understanding about the current family, medical and legal considerations implicit in such statements, but that does not negate their sincerity.

Recommendations

1 That there be widespread objective, public education about the heed not just to make a Will with respect to material possessions, but also in relation to one's person. Legal provision such as the Victorian Medical Treatment Act 1988 with provision for Enduring Power of Attorney (Medical Treatment) and Refusal of Treatment should be publicised wherever it is available in Australia. Where such legal provision is unavailable, every effort should be made to introduce such legislation. The relevance and possibility of making a "living will" or "Advance Directive" while still competent to do so, should be discussed openly at all age levels starting at the secondary school level. This is every bit as much a valid component of "Human Biology courses as are sex education and parenting issues.

2. That there be widespread public education and debate about the concepts of voluntary euthanasia/dying with dignity/right to die. I believe that education and information should be encouraged and actively promoted by government as occurs with other major public health issues. It should not be left to editorial decisions by media where the emphasis is inevitably on dramatic crisis situations.

3 That there be a change in the Federal and State laws so that medical and nursing professionals who assist a mentally competent person to implement a well-documented decision to end their life are not legally or professionally compromised.

Yours Sincerely

Alice Glover MB.,BS,, Ph.D.