



# The Australian Family Association (NSW)

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Committee Secretary  
Senate Standing Committee on Legal and Constitutional Affairs  
Department of the Senate  
PO Box 6100  
Parliament House  
Canberra, ACT 2600

## SUBMISSION

### **Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008**

To open its submission, the Australian Family Association invites the committee to read the following personal testimony from a member of the AFA.

“In 1998, my sister became a quadriplegic from a spinal abscess. Within a couple of days of an operation to drain the abscess it was determined that she had sustained spinal cord damage due to the compression on the spinal cord and that she was now a quadriplegic. At this initial stage my sister was on respiratory support.

A family conference was held with the intensive care doctor about four days after my sister was admitted to hospital. At this meeting the doctor informed the family that the time had come to withdraw the respirator and determine my sister’s ability to breathe independently. The doctor’s prediction was that my sister would almost certainly require permanent respiratory support, and that if this were so, once she became aware of the seriousness of her situation she would very likely become depressed.

The doctor said that if after 6 weeks (only 6 weeks) my sister were still depressed she would be asked if she wanted to die and if she indicated that she did, they (the medical fraternity) would make her “comfortable”.

The family asked the doctor how the actor, Christopher Reeves, managed and so the doctor described a portable respirator that was attached to his wheel-chair. When asked what was stopping my sister from having the same, the doctor replied that “he (Christopher Reeves) has a reason to live”.

The clear impression given to the family was that the doctor did not see any reason my sister had for living.

The family made it very clear that making my sister “comfortable” was tantamount to euthanasia, and that the family was united in its opposition to taking such measures.

The respirator was not removed as quickly as first planned, giving my sister about eight more vital days to become stronger. When it was removed on about day eleven after being admitted, she breathed independently.

My sister spent the next few months in rehabilitation and finally moved to a nursing home where she enjoyed the friendship of the residents and staff and the local community. She did get depressed at times, and even made statements indicating that she would rather be dead, but with the support and love of her family, and the warmth and compassion of her carers, she always overcame these periods. Instead of being stuck in a state of depression as forecast by the intensive care doctor, my sister grew in fortitude and acceptance.

Having a sister suddenly become completely dependent on others for all her care meant that we as a family had to rearrange its priorities, forego other activities and interests, and stretch its resources to accommodate her needs. Paradoxically, it was precisely this experience that helped the family grow in patience and understanding, and feel more keenly the joys of life, and which brought the family closer together.

Had we been a different family, we may not have challenged the intensive care doctor who seemed in a rush to remove respiratory support for my sister in those vital early days. Had we been a different family, we may have been persuaded to accept that depression was a good enough reason to end my sister's life by making her "comfortable". Had we been a different family, each member might now be bearing the burden of an interior, but serious conflict caused by such a breach in family love and confidence.

My sister lived for six years after becoming a quadriplegic. What took her life in the end was a complication of pneumonia. On this occasion she was hospitalized and every effort was made to save her life. When it was clear that her organs were failing, the doctors took the family respectfully aside to inform it of the seriousness of her condition, and to hear the family's wishes.

The family chose not to go to extraordinary means to keep my sister alive. Her number was clearly up. We gathered once more and maintained a prayerful vigil at her bedside as her mortal life slipped gently away. She was at peace and she was loved to the end.

My sister taught me so much. It is not who we are, where we live, what we can achieve, or how free we are of pain and/or disability, but rather love that makes a life worth living."

This personal testimony raises some points worthy of consideration by the committee, and which can be considered under the following headings:

**1. Assisted Suicide and the Law.** In 1998, as now, euthanasia was illegal in Australia, and yet in a major teaching hospital, at least one doctor suggested to relatives that measures to hasten a patient's death could be offered to relieve the patient's distress even though it was not an option sought by the patient or relatives.

This suggests that at least some doctors have little regard for the law and seek to be push the limits of the law that are in place to protect citizens. If the law is relaxed, this will not keep such doctors within the law, but rather sets a wider boundary against which they will push.

A law which would legitimize the action of a "suicide assistant" (one who assists in the death of another) would also send a strong message to the community that some lives are expendable. Once that first step is taken, the definition of "who is expendable," will always be subjected to the shifting sands of opinion.

**2. Vulnerable People.** Patients and relatives can be very vulnerable as they deal with the strain of dislocation, exhaustion, fear of unknown outcomes, the change in the dynamics of family relationships, piling expenses and so on. Against this back drop, patients and relatives may find it difficult to see things in a positive light and can be very open to suggestion.

If assisted suicide became legal, it may become difficult at a time of such vulnerability to resist the supposed relief that suicide would bring.

**3. Depression.** When a patient's condition is particularly grave, painful, protracted, and requiring high levels of care and intervention, depression is often experienced, and at times the patient will indicate a wish to die. What is needed by such patients is to feel loved, supported and valued and to have their symptoms treated properly.

For a doctor, as above, to have illegally suggested euthanasia as an option for a patient with short term depression, when both the patient and relatives were at a critical point in coping with the sudden onset of a serious condition, indicates that were euthanasia laws to be repealed, proper treatment of people with depression could easily be bypassed and replaced with the offer of assisted suicide.

It should be remembered that depression is a major factor in those seeking assisted suicide.

**4. Palliative Care.** Good palliative care for those facing the end stages of life can bring peace and comfort to both the patient and the relatives. There is no need for people to suffer needlessly. Palliative care experts administer pain relief and other measures carefully in an atmosphere of dignity and love - where life is valued, and death arrives at its own pace.

As our population ages, more resources should be directed into palliative care. This is a far kinder solution than assisted suicide.

A nation that authorizes, through legislation, the suicide wishes of its sick and needy is one that is bereft of love. A nation bereft of love suffers the cruelest form of poverty.

The Australian Family Association urges the committee to maintain the ban on Euthanasia and Assisted suicide.

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National Vice-President and President (NSW)