



ACT Right to Life Association

Member of the Australian Federation of Right to Life Associations

Submission to
Senate Legal and Constitutional Affairs Committee

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

Kathleen Woolf, President

9 April 2008

ACT Right to Life Association Inc
PO Box 333 Civic Square ACT 2608
Tel 02 6251 5786

The Bill affects the whole Australian community

The Bill is not in the best interests of the Australian community as a whole in seeking to have euthanasia reinstated in the Northern Territory or enabling its legalisation in the ACT and Norfolk Island. The populations of those areas are small and their local governing bodies are correspondingly constituted by small numbers of parliamentary representatives. They do not have a house of review such as a Legislative Council or Senate. Settlement of such a vital issue as euthanasia, or voluntary euthanasia, is likely to be decided by one or two votes within their respective, single house, legislatures. Passage of the Bill would fuel demands by euthanasia advocates/publicists that the rest of Australia follow with matching legislation. This would be an example of the tail wagging the dog. Further, the enactment of such socially and morally significant provisions in any of these small territories would not be in the best interests for the practice of medicine in those regions. Inevitably 'specialist' outlets would develop where the 'business' would not be expert diagnosis of their condition nor referral to palliative care facilities, but death delivered as requested.

Nor would it enhance the reputation of these territories to become some sort of euthanasia havens for those interstate patients who are experiencing difficulty in the management of their illness.

Northern Territory

In respect of the Northern Territory the Bill's provisions are the apotheosis of democracy. While proposing to return to that Territory legislative powers in respect of euthanasia, the Bill seeks to restore the provisions of the *Rights of the Terminally Ill Act 1995* (NT). Some thirteen years after that Act's enactment in that Territory Senator Brown would presume to know the wishes of the current electors. It is inconsistent in the terms of his own proposals to reimpose this legislation on the people of the Northern Territory whose Assembly would have the burden of moving to repeal the provisions of the flawed *Rights of the Terminally Ill Act 1995* (NT) before moving to a contemporary assessment of the merits of any proposal to legalising assisted suicide.

The matter of euthanasia in the Northern Territory cannot be separated from its chief advocate, architect and practitioner, Dr Phillip Nitschke, who over many years has been has provide assistance, advice and materials to assist persons achieve that end.. Such an approach is in stark contrast to that of those who think that the depressed, the physically or mentally ill or the dying should be given every assistance to overcome their problems

without deliberate intervention causing death Suicidal people need help - not a recipe on how to end their lives.

A research paper co-authored by Dr Philip Nitschke and published in *The Lancet*, revealed disturbing facts about the practice of euthanasia in the Northern Territory in 1996 and 1997, that is, during the short life of the *Rights of the Terminally Ill Act 1995* (RTI Act). The paper carries the admission that fatigue, frailty, depression and other symptoms contributed more to the suffering of patients than any pain arising from their condition.¹ They were nonetheless deemed to meet the requirements of the RTI Act.

A few years ago Dr Nitschke advocated putting suicide pills on supermarket shelves. They would provide a peaceful death for anyone who wanted it, including the depressed, the elderly bereaved and even troubled teenagers. While the provisions of the *Rights of the Terminally Ill Act 1995* (NT) [repealed] which Senator Brown's Bill would restore do not specifically target these groups such a progression in thinking of a prominent advocate of assisted suicide is significant.

The Australian Capital Territory

The ACT Legislative Assembly has seventeen Members, Ministers typically hold multiple portfolios, and the capacity of the ACT Government to hold a wide-ranging, expert Inquiry, such as the legalisation of assisted suicide, is limited.

Prior to 1988 ACT possessed fully elected bodies which advised the federal Department of the Capital Territory on government of the Territory. In 1978 a referendum on self-government had been defeated, with 68 per cent of voters recording a 'No' vote. What was preferred was a municipal form of government without power to make laws in respect of all criminal and civil matters.

Nevertheless, despite the result of the referendum, the Hawke Labor government set up a Self-Government Task Force in 1986 to report on the government of the ACT. The *Australian Capital Territory (Self-government) Act 1988* provided for a fully elected legislature to make statutory law for the ACT, for an executive, and for the independent court system subsequently created under the *ACT Supreme Court Transfer Act 1992*. The good sense of the citizens was ignored.

¹ Kissane, D, Street, A, Nitschke, P (1998), Seven deaths in Darwin: case studies under the Rights of the Terminally Ill Act, Northern Territory, Australia. *The Lancet*, Vol 352, pp1097-1102.

Not unexpectedly, Dr Nitschke has indicated his support for the legalisation of assisted suicide in the ACT if Senator Brown's Bill is passed. The Australian Capital Territory, being comparatively close to the larger centres of population, could face the distasteful prospect of being a centre for "death tourism".

Euthanasia and public health policy

In considering the provisions of the *Criminal Code Amendment (Suicide Related Material Offences) Act 2005* the Senate Legal and Constitutional Affairs Committee called for the implementation of additional broader research, strategies, resourcing and policy initiatives by the Federal Government and state/territory governments in order to address jointly and consistently issues relating to suicide in Australia (Recommendation 4). With access to the promotion of suicide through the internet now restricted by the provisions of that legislation, it would be contradictory for the Federal Parliament to assist facilitation of assisted suicide as promoted by this Bill. To do so would be poor public policy and undermine the ethical foundations of Australia's health services.

Pro-euthanasia groups cannot dissociate themselves from the activities of Dr Nitschke's high-profile advocacy of euthanasia and suicide. Dr Nitschke's 2005 book *Killing Me Softly: Voluntary Euthanasia and the Road to the Peaceful Pill* (Penguin, 2005) is an activist's manifesto, not adverse to dealing with the economics of euthanasia. Noting that end-of-life care is expensive, Dr Nitschke observed that if voluntary euthanasia lopped a mere six months off the lives of ailing elderly, immense savings would result. Therefore he concluded euthanasia would be a good way to trim fat from government budgets:

One can but wonder when a government will have the guts to stop digging the fiscal black hole that is their ever-deepening legacy for future generations. While the enabling of end-of-life choices will not fix the economic woes of the next 40 years, it would not hurt, given half a chance. So the next time you hear a government minister trying to argue why this or that payment or welfare program for single mothers or war veterans must be cut, counter their argument with their fiscal irresponsibility on end-of-life choices.

Dr Nitschke also included prisoners among the potential beneficiaries, mooted voluntary euthanasia as "the last frontier in prison reform".

Dr Nitschke's activities stand in contrast to our national strategy to reduce the suicide rate. Preventing suicide is a very complex issue which requires further significant study and

long term investment. The Australian Government provides approximately \$10 million per year for the National Suicide Prevention Strategy.²

Vulnerable people

In Australia more than 2200 people commit suicide each year.³ That is more than the annual road toll of over 1500 deaths per year that we see regularly reported on the television news.⁴ A study by the World Health Organisation (WHO) found that, despite there being almost one million suicides every year, suicide is a largely preventable public health problem if the right policies and interventions are in place.⁵

Unfortunately, however, a significant pool of young people consider suicide or self harm. Some 7%-14% of adolescents will self harm at some time in their life, and 20%-45% of older adolescents report having had suicidal thoughts at some time. Certainly there is a very high association between suicide in adolescents and depression. Psychological post-mortem studies of suicides show that a psychiatric disorder (usually depression, rarely psychosis) is present at the time of death in most adolescents who die by suicide.⁶

Such vulnerable young people could be pushed over the edge to their death by individuals or groups promoting suicide. If doctors can be involved in assisting patients to kill themselves, as provided for in the legislative provisions Senator Brown wishes to reinstate in the Northern Territory, then another significant barrier to the acceptability of suicide would be removed.

Significant risk factors overall for suicides are major depression, substance abuse, severe personality disorders, male gender, older age, living alone, physical illness, and previous suicide attempts. For terminally ill patients with cancer and AIDS, several additional risk factors are also present.⁷

Given the high association between depression, a treatable condition, and being suicidal, it is important that depression is always considered when suicide is

² New National Advisory Council on Suicide Prevention. Media Release from the Hon Trish Worth MP, Parliamentary Secretary for Health, 29 March 2004.

³ Australian Bureau of Statistics (2004), *Suicides: recent trends, Australia*. 15 December. Catalogue 3309.0.55.001.

⁴ Australian Transport Safety Bureau (2005), *Road Deaths Australia: Monthly Bulletin* January.

⁵ Suicide huge but preventable public health problem, says WHO.. Media release for World Suicide Prevention Day - 10 September. World Health Organisation. Issued 8 September 2004.

⁶ Hawton, K and James, A (2005) Suicide and deliberate self harm in young people. *British Medical Journal*, Vol. 330, pp 891-894.

⁷ New York State Taskforce on Life and the Law (1994), page 12.

discussed. Depression is often missed or not treated properly.⁸

Despite the importance of depression in contributing to suicidal behaviour, it was reported earlier this year that Exit International's director Dr Philip Nitschke refused to seek expert opinion on whether those who approach him are suffering from depression. Dr Nitschke said:

I would say common sense is a good enough indicator. It's not that hard to work out whether you are dealing with a person who is able to make rational decisions or not.⁹

Such an attitude is ideologically resistant to what is known of depression. Depression is more difficult to detect than many other health conditions because those suffering the condition are often unaware of their illness:

Unfortunately, because a common symptom of depression is a loss of insight and a feeling of hopelessness, depressed people usually have little understanding of the severity of their illness. They are often the last to recognise their problem and seek help. It is therefore critical that primary care physicians develop the skills to recognise depression in patients, particularly the terminally ill and elderly, whose depressive symptoms may be masked by coexisting medical conditions such as dementia and coronary artery disease.¹⁰

The law should not compound the suffering of victims of depressive illness and of their families by encouraging suicide rather than providing the help they obviously need.

If it becomes routine to ask for assistance to die then this acceptance becomes a pressure on people to end their lives with the self-justification that they will ease the burden on family while ending their own physical and psychological pain. Fear of dependency and reluctance to burden family members are influential factors in making a decision to commit suicide.¹¹

Euthanasia is not a solution to illness, pain or depression. There is a need to respond creatively to social isolation, and to treat actively all symptoms with early and skilled palliative care. Persons who are clinically depressed may wrongly see themselves as terminally ill. To allow such persons to agree to be killed undermines the protection of the

⁸ Hitchcock Noel, P et al (2004), Depression and comorbid illness in elderly primary care patients: impact on multiple domains of health status and well-being. *Annals of Family Medicine*, Vol 2(6), pp 555-562.

⁹ Pelly, M, A better option: the wait for a way out. *The Sydney Morning Herald*, March 19 2005.

¹⁰ New York State Taskforce on Life and the Law (1994), *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*. New York State Department of Health, page 15.

¹¹ Johnson, T (2003), Book review: Suicide and euthanasia in older adults: a transcultural journey. *Psychiatric Services*, Vol 54, pp 261.

law for vulnerable suicidal people. It says that sometimes people's lives are no longer of value and can rationally be extinguished with assistance - a dangerous notion.

The Australian experience – legal euthanasia in the Northern Territory

Research into the practice of euthanasia in Australia, co-authored by Nitschke and published in *The Lancet*, admit that, for all the prominence given pain in pro-euthanasia advocacy, that fatigue, frailty, depression and other symptoms contributed more to the suffering of patients than did difficulty with pain.

Depression was a major factor in the Northern Territory's experiment with euthanasia, as it is a major factor in the problem of suicide. In a major review of the case notes of seven people who sought euthanasia in the Northern Territory there was evidence of inadequate consideration of depression:

To what extent was the psychiatrist trusted with important data and able to build an appropriate alliance that permitted a genuine understanding of a patient's plight? In case 1, there was important background detail about the death of one child and alienation from another, which was withheld during the psychiatric assessment. These experiences may have placed the patient in a lonely, grieving, demoralised position: an unrecognised depression may have led to suicide.

Four of the seven cases had symptoms of depression, including reduced reactivity, lowered mood, hopelessness, and suicidal thoughts. Case 4 was receiving treatment for depression, but no consideration was given to the efficacy of dose, change of medication, or psychotherapeutic management. PN judged this patient as unlikely to respond to further treatment. Nonetheless, continued psychiatric care appeared warranted.¹²

The Australian experience with euthanasia shows that the significance of depression and psychiatric illness in euthanasia and by implication in suicidal people should not be underestimated. Legalising assisted suicide will not promote understanding, nor improve the management of depressed persons.

Experience in other countries

The overwhelming evidence accepted by parliamentary inquiries into euthanasia conducted in countries across the world is that it is dangerous to give someone the power to kill another person. Vulnerable people who are sick, aged or depressed are inevitably at risk of consenting to be killed rather than getting the help they need.

In those few countries where assisted suicide or euthanasia is legalised there are serious concerns over how legally permitted assisted suicide is applied. In the Netherlands, for example, 1 in every 32 deaths arises from legal or illegal euthanasia. As well, Dutch pro-

¹² See footnote 1.

euthanasia groups are campaigning to further extend grounds for assisted suicide eg to people with dementia.

Experience in European countries illustrate this inevitable 'rationale' for extension of assisted suicide. In the Netherlands a collection of 35 bioethics centres and institutions recently released a statement regarding the Dutch government's announcement that it would extend its euthanasia law to include children. While euthanasia has been openly practiced for two decades, it was only formalized in statute law in 2002. This law allows the killing of patients down to the age of 16; it is now proposed to lower the age to 12. Similar proposals are being considered in Belgium including the euthanasia of children without parental consent. Appeals have been made to the European Union to protect the basic human rights of children and newborns, where consent is not possible.¹³

Lausanne University has announced that it will allow doctors and nurses, in that hospital, to kill patients. The hospital's legal director, Elberto Cresbo, stated "We are not trying to encourage suicide but, at the same time as a hospital, we have to respect the wishes of someone who wants to die."¹⁴ The erosion of medical ethics seems to follow swiftly the legalisation of killing by doctors.

Suicide and the law

Legislators have a responsibility to protect the community, for the common good of all, even if this involves some interference in the interests of some members of the public. It is important to ensure that those who are vulnerable to influence do not have unrestricted access to advice or materials that would encourage or assist them to end their life rather than seeking help. The community has a responsibility to protect vulnerable people and to provide the best medical and social care.

The law also has an educative dimension. Laws such as the Bill under consideration abandons the principle that the life of every human being is valuable, and is silent on the desirability of providing special care to those who are vulnerable. It is for this reason that aiding or abetting a suicide is illegal in every State and Territory in Australia.

A number of organisations and individuals argue that, given suicide is no longer a crime, providing information to assist suicide and actively assisting persons to commit suicide should be lawful. But just because suicide is not a crime does not mean it is a public good that should be promoted or facilitated. Suicide was decriminalised because there was little

¹³ LifeIssues Newsletter 2 221 April 2006. www.lifeissues.net

¹⁴ *The Guardian* 19 December 2006.

value in prosecuting someone who was dead or who had attempted suicide. Suicidal people need help, not prosecution. But there is great value in protecting the general public from people who assist suicide.

Legislators have a responsibility to protect the community, for the common good of all, even if this involves some interference in the interests of some members of the public. It is important to ensure that those who are vulnerable to influence do not have unrestricted access to advice or materials that would encourage or assist them to end their life rather than seeking help. The community has a responsibility to protect vulnerable people and to provide the best medical and social care.

Euthanasia and the churches

Many church leaders have expressed their opposition to making assisted suicide legal. Such opinions are deserving of close consideration as church institutions have historically been in the forefront of providing care to the sick and the dying. For example, in their 2005 consultation Draft on *Advanced Care Planning* the Australian Catholic Bishops' Committee for Doctrine and Morals and *Catholic Health Australia* said:

- 1.2 Catholic ethical and social teachings seek to preserve respect for human dignity at all stages of life, particularly when people are most vulnerable due to illness or disability. In upholding respect for the worth and dignity of each person, we recognise the obligation that each of us has to take all reasonable measures to care for his or her own health, and so to use all "ordinary", reasonably available, and not overly burdensome, forms of effective medical treatment. (*Code of Ethical Standards for Catholic Health and Aged Care Services* [Catholic Health Australia, 2001], I, 1).
- 2.11 No one may rightly direct or ask that an unethical medical decision be made with respect to his or her care. Since euthanasia is wrong in itself, it would be wrong to request euthanasia, that is, to request that life-sustaining treatment be withheld or withdrawn *with the purpose of causing death*. In any case, euthanasia and assisted suicide are illegal in Australia.
- 2.12 On the other hand: "Patients have the moral right to refuse any treatment which they judge to be futile, overly-burdensome or morally unacceptable, and such refusals must be respected" (*Code*, II, 1.16). When a treatment is withheld or withdrawn because it is futile or burdensome the intention is not to end life. Given the continuing debates over euthanasia and the withdrawal of medical treatment, it may be helpful for people reflecting on their future medical needs explicitly to state that they do want ordinary, life-sustaining treatment to be provided unless and until it becomes futile or overly burdensome.

The distinction between treatments intended to relieve pain and discomfort and deliberate action to take life is critical. The former is good medical practice and includes consideration for a patient's choice to refuse any particular treatment; the latter is a denial of the medical principle of *Do No Harm* and makes the doctor an executioner.

In May 2006 moves to approve an assisted suicide proposal in Britain were strenuously opposed by the *Care Not Killing Alliance* which was formed by medical groups, organizations representing disabled people, and churches. Leaders of various faith groups wrote an open letter to all members of Parliament and the House of Lords. The groups, which ranged from Buddhists, Christians, Hindus and Jews, to Muslims and Sikhs, expressed their concern at the attempt to change the law and added that they held all human life to be sacred and worthy of the utmost respect.

Just prior to the parliamentary debate, Anglican Archbishop Rowan Williams of Canterbury, Cardinal Cormac Murphy-O'Connor of Westminster, and Chief Rabbi Jonathan Sacks wrote to MPs urging them to take steps to ensure adequate training is given to doctors and nurses to adequately treat such patients. They also asked that more centres of specialist palliative care be established. They noted that in countries where assisted suicide or euthanasia is legalized there are serious concerns over how it is applied.¹⁵

The Lords voted 148-100 to postpone the debate. The British Medical Association continues to oppose assisted suicide or voluntary euthanasia.

The euthanasia movement - a slippery slope?

It is too easy to disparage as a slippery slope argument reasonable predictions of the consequences of certain laws and/or practices. Legal permission for doctors to directly kill patients with their permission has led to an extension of the concept of voluntariness. It is too readily argued that, if the competent are to exercise choice to relieve their distress, then why should the same freedom be denied to the incompetent? If distress or loss of will to live is appropriate for those who are elderly or afflicted with a terminal illness, why should relief be denied to the young and those suffering the burden of mental illness?

In 2001 Dr Nitschke told US *National Review* that he chose to restrict himself to helping the group of “terminally ill adults who are articulate, lucid and not suffering from clinically treatable depression”. However he signalled a shift in the same article. “Someone needs to provide this knowledge [of suicide methods], training or recourse necessary to anyone who wants (death), including the depressed, the elderly bereaved, [and] the troubled teen”.¹⁶

¹⁵ *The Times* 12 May 2006.

¹⁶ Lopez, K J (2001), Euthanasia sets sail. *National Review Online*, 5 June.
<http://www.nationalreview.com/interrogatory/interrogatoryprint060501.html>

During the period of operation of the *Rights of the Terminally Ill Act 1995* (NT)

Dr Nitschke was involved with highly publicised cases of people who were not terminally ill. It began with Nancy Crick. After her suicide it emerged that Crick was not terminally ill - a fact Nitschke had not publicly revealed. Crick was what the international euthanasia movement calls "hopelessly ill", a new catch-all category to include those who don't fit the definition of terminal illness.

This was a significant and frightening new step in the Australian euthanasia debate.

Later the NT suicides of Lisette Nigot, a woman called Ruth, and Syd and Marjorie Croft, all in relatively good health, helped the euthanasia lobby take things even further.

Terminal, even "hopeless" illnesses were no longer needed as justification for suicide or euthanasia. These actions were portrayed as rational suicides.

The concept of rational suicide greatly expands the range of people at risk from euthanasia activists. It could include those living in social isolation, those with physical disabilities or even business people who go bankrupt. One person's sad and desperate cry for help is another person's rational suicide. Death is all such groups have to offer. The cause of physical, mental or spiritual hurting will not be addressed. The difficult question of how to help suicidal people avoid a self-destructive course will be left unanswered.

Limits to autonomy

It is often asserted by pro-euthanasia that to restrict assisted suicide is to restrict a person's autonomy to take charge of their own lives. Autonomy of the individual is not an absolute right. What may appear like an exercise of choice in choosing assisted death is that these persons may be suffering depression which can foment suicidal thoughts.

The exercise of one's person's autonomy, especially as approved by law, will increase pressure on the depressed, the frail, the elderly, and the confused to request euthanasia. People in those circumstances often feel they are a burden on relatives and consuming too much of society's resources. A law allowing euthanasia or assisted suicide, by legitimatising that option, removes the bulwark which should protect such persons from themselves and from those who might out of self-interest exploit their weakness.

During the debate on the Lord Joffe's 2006 UK euthanasia provisions Jane Campbell, a Disability Rights commissioner, explained how she suffers from a severe form of spinal muscular atrophy. "Many people who do not know me," she commented, "believe I would be 'better off dead.'" This sort of view is based mainly on ignorance, or even prejudice, argued Campbell. Lord Joffe's Bill failed to get the endorsement of a single organization

of disabled people. Groups representing the terminally ill and disabled, frightened by what the bill seeks to achieve, formed a coalition, *Not Dead Yet*, to fight the proposal.¹⁷

Conclusion

Palliative care is advancing very rapidly, both in relieving suffering experienced by those with a terminal illness, as well as in providing support for their families. Politicians should take steps to ensure adequate training is given to doctors and nurses to adequately treat such patients; they should also fund the establishment of centres of specialist palliative care. They should ensure that the law continues to affirm the principle that life is precious especially in its most challenged, vulnerable moments. The attachment is an eloquent statement of these principles. They would be best protected by rejection of Senator Brown's Bill.

¹⁷ *The Guardian* 9 May 2006.

Attachment

Odette Spruyt*

The Age 5 February 2007

RECENT articles and letters after the death of Dr John Elliott have presented dying in Australia as a fearful and terrible experience. People are said to suffer not only physically but also a total loss of dignity such that desperate people have no choice but to take extreme measures.

Human dignity is presented as totally dependent on fragile externals. We lose our dignity in the face of suffering, be it physical, emotional or social. We lose our dignity if we lose control of our decision-making capacity, our bowels, our mobility, our mind. We lose our dignity if our loved ones can't or won't care for us and we refuse to let others do so.

The subversive practice of giving patients lethal doses of morphine is portrayed as commonplace and indeed necessary for pain-free dying within the constraints of what is inferred to be archaic, inhumane and ineffective health care for the dying.

I have worked as a specialist palliative care doctor for 13 years. The exposure to death and dying daily has taught me many lessons. When I read the story of Elliott, some apparent absences are disturbing: the absence of an extended care network, the absence of any mention of palliative care/pain management expertise, the absence of the will to live (portrayed as somehow heroic). This is one man's story. It is certainly not everyman's story.

In Australia over the past 10 years, there has been an impressive increase in the range of pain management drugs. We now have more than 10 strong pain killers (opioids) that can be given in many different ways so that finding the right drug for the individual is now possible. In addition, we have a vast array of supportive pain-relieving drugs that can be combined with the opioids, to safely minimise the dose of opioid and optimise pain relief. Combinations often achieve more than one drug alone but are more complex for the patient, carer and doctor to manage, hence the need for specialist palliative care/pain management assistance.

Added to the medications now available are many other treatments such as radiotherapy, specialised anaesthetic techniques for cancer pain relief (such as epidurals), neurosurgical techniques and anticancer treatments, which may reduce the tumour size and activity and so reduce the tumour-associated pain. We also have a national, free palliative care network, available to all, providing care for the dying in hospitals, hospices and at home.

It is simplistic to argue that palliative care can remove all suffering at the end of life. However, why is it that at a time of such greatly improved analgesia and systems of care, the envy of many countries worldwide, there appears to be such a great fear of dying in unrelieved pain and suffering? Our resources have never been better. Why are people being told that there is nothing to help them?

As a community, we do need a better understanding of palliative care as specialised health care for those approaching death. Palliative medicine is also not well understood by the medical community, which leads to ignorance in the use of analgesics, even by experienced doctors. For example, it is inaccurate to say that such large doses of narcotic analgesia as would suppress breathing and shorten life are necessary to relieve pain in the dying.

A recent review of hospice practice showed that the norm is modest doses of opioids in the final 48 hours of life. This is evidence that with best total care, extreme dosing is not required for a peaceful death and may in fact achieve the opposite due to side effects. In addition, such rhetoric reinforces the negative stereotypes that abound about the medical use of opioids and prevents many patients from accepting appropriate pain relief out of fear that these drugs will kill them.

However, perhaps it is not the fear of pain and suffering but rather a fear of death itself that drives this issue.

In fact the fear of death may be greater than ever before in our youth-oriented culture. Perhaps we need to slow down. In our rush to the finishing line, we are failing to see:

- The tireless devotion of a young wife for her dying husband.
- The marriage in hospital of a long-together couple two days before his mother dies.
- The exquisite intimacy and tenderness of a mother as she cares for her dying 20-year-old daughter.
- The laughter of families as they reminisce around the bedside of their father.
- The children doing puzzles on the floor of their grandmother's hospice room.
- The daily courage and dignity of the ill in the midst of incontinence, pain, tears and grief.
- The urgency in the steps of the nurses intent on relieving the pain and distress of their patient.
- The friendship and love which grows between staff and patients in the midst of adversity.
- Life renewing in the face of death.

We may crave for a way to circumvent the pain of dying, the grief, the loss and the seeming uselessness of it all. We may prefer a neater exit of our own time and choosing. However, we risk anaesthetising ourselves from life, and losing much of its richness, mystery, beauty and soul.

Instead of running from death, we need to embrace those who are dying within the community of the living and ensure that they know they are a vital part of life until their last breath.

* *Odette Spruyt is a palliative-care doctor at Peter MacCallum Cancer Centre.*