



COMMONWEALTH OF AUSTRALIA

PARLIAMENTARY DEBATES



THE SENATE

PROOF

MATTERS OF PUBLIC INTEREST

Palliative Care

SPEECH

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BY AUTHORITY OF THE SENATE

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Speaker Polley, Sen Helen

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Senator POLLEY (Tasmania) (1.33 pm)—I rise today to speak on a matter of public interest and what I believe is a matter of importance to all Australians—that is, palliative care. Any discourse on this subject requires clear definition. Palliate means alleviating disease without curing it. Palliative care is the specialised care of someone who has advanced terminal illness. In essence, this matches the vision statement of the Tasmanian Association for Hospice and Palliative Care, TAHPC, which reads ‘Quality care at the end of life for all’. This clearly states that such care should affirm life and accept dying as a normal process. This is a consistent ethos which flows from the World Health Organisation to all Australian palliative care agencies.

I draw attention to recent announcements in the media with regard to palliative care in this country. The first of these was the major release from the Minister for Health and Ageing, Nicola Roxon, at the commencement of National Palliative Care Week 2010 which outlined increased funding for and a clear strategy to further improve services to the 520,000 Australians who are affected by this traumatic experience each year. When we talk about 520,000 Australians we also have to remember the impact on their families and their communities. In total, \$14.3 million has been allocated by the federal government to fund care, training and research programs designed to assist staff, families and patients to cope at such a trying and emotional time. Indeed, this is a most challenging time for all involved—the families and those who care for the patients and, of course, the patients themselves.

The importance of this commitment by the federal government should not be underestimated. Other governments around the world are choosing to investigate alternative options for dealing with palliative patients which attack the very fabric of civilised and Christian societies. Canada is a prime example of a country entertaining such radical solutions. On 16 March this year, the Canadian parliament debated bill C-384 which aims to legalise euthanasia and assisted suicide. Three days later, a Tasmanian newspaper published an article which would tear at the heartstrings of any parent. Melwood Young People’s Room has been created to enable young people in palliative care to remove themselves from the main centre which is generally filled with much older patients. This new environment is full

of modern technology and has been created for young people under 25. It is saddening that these individuals who have really only just begun their lives are using this facility to prepare for death. Despite this stark reality, it is commendable that young Tasmanians such as Marg Hughes and her team continue to provide stimulating environments and creative innovative programs which enhance the wellbeing of those who are dying. It is important that young people in this situation stay connected to the outside world. The use of technology provides a fun, attractive and age-appropriate space for young people facing end-of-life issues and also serves the dual purpose of diverting focus by creating vibrant activities when friends and family arrive to visit.

The Melwood Unit is also about to initiate an artistic program for all patients which can provide loved ones with another lasting and positive memory. Using art as an avenue for personal expression and communication is not a new concept, but in this context it provides a meaningful and engaging creative opportunity for patients. Such an attitude of innovation, preparedness and support reflects the efforts of the Australian government to facilitate quality programs which aim to continue positive development of palliative care services.

Since 2007 the Rudd government has provided more than \$55 million to promote national quality standards, support patients and their families, increase the knowledge and skills of the health workforce and improve access to medicines. In stark contrast, overseas politicians admit:

... we do not have anywhere near the services in palliative care ... that we should have.

...

Until we are in a position to complete the building of the medical infrastructure that we need to support patients—

this measure is ‘premature’. That is Canadian MP Joe Comartin referring to bill C-384. Dr Els Borst, the architect of the Dutch euthanasia laws admitted the Netherlands should have pursued advances in patient care before considering euthanasia. Comartin said of her:

She recognized they did not have anywhere near a full system of palliative care in Holland.

I cite some experiences of Dr Frank Brennan, a noted palliative care physician who gives a valuable insight into the dedication of our healthcare professionals. Recounting a case, he said:

I met her at the main hospital ... Her disease had progressed, and her options were rapidly diminishing ... I talked to her about palliative care ...

... ..

By the week's end she had deteriorated further ... Jack—
her husband—

sat by her bed, as usual ... I explained the process of dying and said that I did not think that it would be long. There was a pause. Finally, Jack looked up at me and asked: "Doctor, can't you give her a needle ...?"

I'd heard the question before, from relatives of other patients, at other deathbeds. I knew that the sentence would end with "... a needle to end her suffering" or "... a needle to put her out of her misery." I was ready with an answer, prepared and clear: "No, ethically and legally we cannot cause any one to die or hasten their death and that the natural process of dying, already progressing, would inevitably lead to her death."

But the sentence did not end that way ... He completed the sentence by saying, "Doctor, can't you give her a needle to wake her, so that we can speak one last time?"

Recalling another case, Dr Brennan said:

He had been deteriorating ... It was time to discuss the future. When I arrived at his room I was pleased to see his wife, her presence would make communication easier ...

... death was approaching ... from now on, the most important things were to keep him comfortable and for him to share his time with his family ...

His wife stood at the end of the bed ... She said, "We've had a great life together you and I. My darling we have".

He said, "Well if that's it, that's it. Everyone has to go through it I suppose and now" he said, looking up toward her "it's my time".

... ..

I said that I thought he would not suffer any more than he had and that we would do our very best to ensure his comfort. I said that more than any medication we could give, the most important thing now was love—reflecting on their time together as a family and their love for him as a man.

... ..

I was reminded of the deep significance of those words ... such as death and dying, hope and reflection ... A patient recently said to me, "Never underestimate the power of your concern".

... ..

I stopped speaking. I looked back into the eyes of the patient. "Go on doctor" he seemed to say, "you're doing alright" ... Each member of the family took turns to come up to him. They leant over to look directly into his eyes ... each kissed him ... It was a ceremony of immeasurable grace.

As unobtrusively as I could I began to leave the room. The deaf mute man, Anne's father, now carrying the baby turned from the huddle surrounding his father-in-law. He stepped toward me, reached out and shook my hand. He mouthed the words "thank you". I wept, I wept for the singular beauty of what I had seen that afternoon, for the courage Anne had shown, I wept for their love, I wept for all the patients, on all the days and for the sadness of leaving. And finally for this small act of decency that a grieving man would interrupt such an intimate moment with his family to turn and thank me. I rarely weep. Long ago I abandoned the question of whether it is professionally appropriate or otherwise. Now, I do not worry either way.

We are humans working in the most human of enterprises. Our tears whether they are shared often, rarely, or never are part of us as much as our skills, our knowledge, and our presence. Anne's father looked at my tears, reached over and rubbed my elbow ...

The baby, mirroring his action reached out. I lifted the baby into my arms ... as one life is coming into the world, one is going out.

This underlines that we all start life dependent on someone else, and more and more Australians are finishing life reliant on others. The Australian government's third *Intergenerational report* projects the number of people aged over 85 will quadruple by 2050 to almost two million. Our Labor government is already planning and ingraining funding to address potential issues in relation to that statistic. Australia's substantial financial investment in palliative care and long-term planning strategies when considering an individual's final days are compassionate and commendable.

It is possible that a generation who grew up enjoying green environments, mobile phones, flat screen televisions, the internet and iPods will be demanding information, guidance and medical input into the ultimate transition, when moving on from advanced illness. Hence, many Australians will revisit the way they contemplate and approach death. Palliative care is a critical component of health care in this country. All those who work within it are specialised. They are some of the most caring and compassionate people in our society. They deserve our support, our respect and our thanks for the wonderful job they do not only for the patients and their families but for our society. Palliative care is a very personal issue for too many Australian families, but it is an issue that we all need to be aware of. Palliative care is certainly the best alternative to attempts to legalise euthanasia in this country.