



# the last stage of our journey

PALLIATIVE CARE  
AND THE END OF THIS LIFE

We enter the world entirely dependent upon other people. Most of us will also live our final months, weeks or days in this world requiring the care and support of others to sustain us. While dying is an intensely personal experience, it is also a journey which we should not have to undertake alone.



CATHOLIC ARCHDIOCESE OF SYDNEY  
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Good quality care at the end of life is integral to a comprehensive and 'waste of the healthcare dollar' to care for people who are dying. Although their lives, dying people should never be regarded as 'unproductive' or sisters who are worthy of quality health care, reverence and love. However, an important indication of how compassionate and humane we are as a society.

## Providing a good life for the dying

Australia has the capacity to provide good palliative care. Palliative care is a specific discipline within medicine. It specialises in care and support that recognises the unique needs of a person who has an advanced or life-threatening illness, and of their family and carers. Not everyone in the final stages of life will experience pain, but if patients do experience it, in almost all cases it can be relieved. Health professionals and our health system should strive to improve quality of life for patients, their families and carers by providing care that addresses physical, emotional, social, cultural and spiritual needs. The aim is to help the person live as well as possible; not to die as soon as possible!<sup>1</sup>

### palliative care

affirms life and regards dying as a normal process;

provides relief from pain and other distressing symptoms;

neither hastens nor postpones death;

integrates the physical, social psychological, emotional and spiritual aspects of patient care; and

helps people to live as actively as possible until death.<sup>2</sup>



## Neglect versus untiring service

Euthanasia, sometimes called 'mercy killing', is the deliberate killing of another person with the motive of ending his or her suffering. This can be achieved by doing something (e.g., giving a lethal injection) or by failing to do something (e.g., withholding life saving treatment or care, including food and water) with the intention to cause or hasten death. The defining feature of an act of euthanasia, therefore, is the intention to deliberately bring about a person's death.

By contrast, palliative care is aimed at supporting people at the end of their life and thereby recognises the dignity that person bears until the moment of their death; it never involves an intention to end a patient's life. It seeks to eliminate suffering by treating symptoms; not to eliminate the sufferer!

***Even when not motivated by a selfish refusal to be burdened with the life of someone who is suffering, euthanasia must be called a false mercy, and indeed a disturbing "perversion" of mercy. True "compassion" leads to sharing another's pain; it does not kill the person whose suffering we cannot bear.*** (The Gospel of Life, 66).

As a Sydney-based palliative care specialist explains:

*When fears are addressed, the process of adjustment discussed, symptoms are managed, continuity of care is provided without abandonment, depression is treated, and the person's value and sense of worth reaffirmed without implication of burden, most will again be empowered and choose life. A sense of certainty, dignity and healing is restored for these patients and those who care for them.<sup>4</sup>*



The Catholic Church has a great and ongoing tradition of caring for the ill and dying and for their families. Across Australia Catholic providers operate over 19,000 residential aged care beds, together with eight dedicated hospices and palliative care services, and provide around half of all palliative care for the dying.<sup>3</sup>



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## Euthanasia disguised?

The euthanasia lobby sometimes argues that doctors covertly practise euthanasia by administering large doses of pain-killers to dying patients. However, there is a real difference, both ethically and legally, between intending pain relief and intending death. In most cases, there is a clear distinction between the dose which relieves pain, and the dose which over-sedates. Doctors occasionally foresee that giving increasing doses of pain-killers or sedatives to comfort a patient may also have the side effect of shortening that patient's life (just like any medication may have side-effects). But where the intention is to relieve suffering and not to hasten death, these doctors are not performing euthanasia.

*In such a case, death is not willed or sought, even though for reasonable motives one runs the risk of it: there is simply a desire to ease pain effectively by using the analgesics which medicine provides. (The Gospel of Life, 65)*

Palliative care sometimes also involves the withdrawal of medical treatments which have become futile (are no longer working) or overly-burdensome for a patient, even where it is foreseen that this may cause death to come sooner. Again, this is not the equivalent of euthanasia or suicide, but an acceptance of the human condition in the face of death, and reflects the prioritisation of the comfort of patients and the easing of their distress. It is very different from a choice to refuse treatment because we judge *life* to be futile or overly burdensome.



## What about food and fluids? Can these be withdrawn?

These decisions are made on a case by case basis. The Church teaches that the provision of nutrition and hydration is 'ordinary care', and the presumption is that they should always be provided, unless the patient has reached a stage where the provision of food and water is futile or would be unduly burdensome.<sup>5</sup> The withdrawal of food and fluids must never be done with the intention of causing or hastening a person's death. However, it may be permissible when death is imminent, in order to allow a patient to die more comfortably or when there is no medical or symptomatic benefit from such treatment (i.e the treatment is not helping the patient to live longer or feel better).

## A junior doctor's story

*Working on the cancer ward I have many patients with multiple complex symptoms. Most of these are easily solved with basic adjustments to medications, however Joe was different. He came in with intractable nausea and it took us many weeks of trialling various doses of several different anti-nausea medications before we seemed to be getting anywhere. It was during this time of experimenting that he looked at me - his entire body weary with long, unforgiving, nauseous days - and told me that he felt his life was no longer worth living. That's how bad his nausea was making him feel!*

*Eventually, our Palliative Care specialists got the dosage right, and he was discharged home with medications that his family was taught to administer through needles into his belly. But this was completely worth it - Joe simply wanted to be in his own home, surrounded by his family, able to converse and interact with them, for as long as possible. With good palliative care measures, we had made it happen. He was a patient who required a lot of time and effort to sort out, but as doctors we are obliged and fulfilled by making that effort for our patients.*





## The increasing need for palliative care

Sadly, there are still people in our community who are not dying well. Too often this is because people are unable to access the care they require, perhaps because of insufficient funding, services and expertise, or because of a lack of understanding of what palliative care is able to offer.

It is crucial to improve access to and development of palliative care services, rather than promoting inhuman ‘solutions’ to suffering like euthanasia and assisted suicide. These two responses to suffering are very different; while palliative care always upholds the dignity of the patient and strives to serve their needs, euthanasia and assisted suicide implicitly state we can give up on striving to improve the lives of our patients – when a patient’s pain, nausea or depression is no longer “worth” fixing.

Medically assisted killing denies the truth that “the request which arises from the human heart in the supreme confrontation with suffering and death, especially when faced with the temptation to give up in utter desperation, is above all a request for companionship, sympathy and support in the time of trial. It is a plea for help to keep on hoping when all human hopes fail.”<sup>6</sup>

Even if in some instances palliative care is unable to relieve all a patient’s suffering, unlike euthanasia, it will always affirm a patient’s inherent dignity. As Dame Cicely Saunders, a leading figure in the development of palliative care famously said:

***“You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die.”***

Of course, professional or specialised palliative care is only ever one aspect of caring for people at the end of life. The deepest human need is love – the knowledge that we are not alone.

***“Dying does not always require health-care intervention, but it will always need human support – someone to sit with people and support them in their final journey.”***

Professor Margaret O’Connor, President of Palliative Care Australia<sup>8</sup>

In most cases, it is a dying person’s loved ones – their family and friends – who are best able to provide this care. Together we all share the responsibility to offer our time, acceptance and love. We all share the work of creating an atmosphere in which a dying person can search for meaning and discover hope. We all share the honour of praying with and for our loved ones who are dying and encountering and serving the presence of God within them.

“Charity sees in the dying person, as in no other, the face of the suffering and dying Christ calling out for love. Charity to the dying person - this “poor one” who is renouncing all the goods of this world - is a privileged expression of love of God in one’s neighbour.”

(cf. Mt 25:31-40).”

(Charter for Health Care Workers, 132)

## How can I plan for my future care?

Catholic Health Australia offers **A Guide for People Considering their Future Health Care**, a free resource for patients and their families which may be downloaded from our website at the link below. This resource is a positive alternative to those “advance directives” which sometimes reflect attitudes and values not in harmony with Catholic ethics regarding the end of life.

A Guide for People Considering their Future Health Care offers patients an option for expressing their wishes for their future care that is in harmony with Catholic teaching on the sanctity of life and ethical withdrawal of treatment.

[www.lifemarriagefamily.org.au/files/FutureHealthCare.pdf](http://www.lifemarriagefamily.org.au/files/FutureHealthCare.pdf)

1. “What is palliative care?” Palliative Care Australia. ([www.palliativecare.org.au](http://www.palliativecare.org.au)).
2. <http://www.who.int/cancer/palliative/definition/en/>
3. Catholic Health Australia, Palliative Care Policy 2010. <http://www.cha.org.au/site.php?id=899>.
4. <http://www.catholicweekly.com.au/article.php?classID=2&subclassID=56&articleID=5383&class=Comment&subclass=Opinion>
5. Briefing note on the obligation to provide nutrition and hydration, Catholic Health Australia,

- Bishops Committee for Doctrine and Morals, Bishops Committee for Health Care.
6. The Gospel of Life, 67.
7. Dr Robert Twycross, “A Tribute to Dame Cicely Saunders”, 8 March 2006. Available at <http://www.eolc-observatory.net/history/cicely.htm>.
8. <http://www.cam.org.au/life/national-palliative-care-week.html>