

TRANSCRIPT

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

Inquiry into end-of-life choices

Melbourne — 18 November 2015

Members

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Witnesses

Monsignor Anthony Ireland, episcopal vicar for health, aged and disability care, and

Father Anthony Kerin, episcopal vicar for life, marriage and family, Catholic Archdiocese of Melbourne.

The CHAIR — I welcome and thank very much for joining us Monsignor Anthony Ireland, the episcopal vicar for health, aged and disability care, and Father Anthony Kerin, the episcopal vicar for life, marriage and family from the Catholic Archdiocese of Melbourne. Thank you both for joining us. Before I invite you to make your presentation I will caution that all evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975, and further subject to the provisions of the Legislative Council standing orders. Therefore you are protected against any action for what you say here today, but any comments made outside the hearing are not afforded such privilege. Today's evidence is being recorded. You will be provided with proof versions of the transcript in the next week or so, and transcripts will ultimately be made public and posted on the committee's website. We have allowed an hour for our session today. I would like to thank you for your submission, which the committee has received and read and has in front of us. Again, thank you both for being here today and I invite you to make your opening presentation, and thereafter the committee will have questions.

Msgr IRELAND — Thank you very much, Chair, and members of the committee. We thank you for the invitation to discuss with you the submission made to the committee for the Catholic Archdiocese of Melbourne, with the endorsement of the other Victorian Catholic bishops. My name is Monsignor Anthony Ireland. I am the episcopal vicar for health, aged and disability care in the Archdiocese of Melbourne, and I am accompanied by Father Anthony Kerin, the episcopal vicar for life, marriage and family in the archdiocese. Father Kerin and I come before you on behalf of the Catholic Archbishop of Melbourne, as two of his eight episcopal vicars to whom he delegates his authority in our respective areas. We also come before you as longstanding parish priests in the archdiocese. We are pastors who have journeyed with people from birth to death, and between us we have almost 70 years of experience accompanying the living and dying.

We thank the committee and the Legislative Council for this inquiry and for the thorough manner in which you have undertaken it, and the sheer volume of submissions that you have received and the hearings that you have conducted demonstrate the level of engagement that end-of-life choices animates within the community. We have noted that the arguments put in the submission of the Catholic Archdiocese of Melbourne to the committee are supported by numerous experts in the field of end-of-life care, and these have included individual doctors and nurses, academics and non-religious healthcare providers. We also note that some submissions have tried to dismiss the position of the Catholic Church and other religious groups as fanciful and frivolous.

We have noted that submissions advocating euthanasia have their origins in poor experiences of end-of-life care. Some of these experiences are historical, but they are seared into the memory of family members who carry the burden. However, it is unfair to judge current practice on experiences of 18 or more years ago, and sad and traumatic though those deaths may have been, good public policy should not be based on poor practice from that time or even now. Similarly it is not reasonable to quote statements about the efficacy of palliative care from years ago rather than current practices and statements. We note that the evidence is that as a society we can do a lot better in the provision of good end-of-life care. The Catholic Archdiocese of Melbourne does not come to this committee with fanciful or frivolous arguments. We come as a significant corporate Victorian citizen and a very interested party that either oversees or provides care at many stages of life's journey.

I have probably said this before on another occasion, Chair, but for the members I will repeat it. In 2014 Catholic providers in the Archdiocese of Melbourne cared for 4500 people in aged care, and 876 185 cases received treatment or stayed in Catholic hospitals. We are involved in disability care, mental health care and other services for another 12 000 people. We are a significant participant in the care of vulnerable people. Our submission is not opinion, nor can it be dismissed as the view of religious fanatics. Our submission is evidenced in fact, borne of long practical experience of service and supported by eminent experts in the field.

Visual presentation.

Msgr IRELAND — The slides that will come up are all slides from the House of Commons, so I am going to illustrate our position with the speeches of the parliamentarians in the House of Commons during the September debate.

Let me make this a little bit graphic so that you can understand how serious we are. I have been sprayed by dying people's vomit in hospitals, in nursing homes and once over some nice shoes in a man's own home. I have sat with dozens of people, helped hold the bowl as that awful dark green vomit shoots out unexpectedly. Almost always people apologise, and always when surrounded with love and care they want to grasp every last moment of life.

Again, from our practical and lived experience — Father Kerin is currently a hospital chaplain at Eastern Health — we would like the opportunity to address the committee, and Father Kerin particularly, on a subject raised in the Auditor-General's report about the provision of palliative care services in regional Victoria. We note that the committee has heard significant testimony from Barwon Health, which aligns with the submission of the Catholic archdiocese.

On 19 January 1988 I arrived as a newly minted priest in the parish of Mentone for my first permanent appointment. Either that day or the next day I was taken around by car by the dean to see all the places that I would have to visit each week or fortnight. That afternoon I did my first visitations. On my very first afternoon on my very first appointment a gentleman who was a resident in Corben House asked me this question: 'Why can't they just put me down? I am useless'. We discussed that a little bit and why he was useless, and I asked him if he could hold his question till the following week when I was due to come back. That gentleman was still going strong when I left Mentone parish in September 1990. He had moved across the street to a higher care facility but he was going well. He had felt useless, but that did not mean he either was useless or that he should be put down. He could not do the things that he had done before, but he just needed to feel valued.

The world-renowned ethicists Smith and Purlin clearly indicate that it is far too easy to argue that the request to be euthanased or to be assisted to suicide is simply because one's physical body has collapsed or due to mental disturbance. Along with the late German ethicist Bernard Häring, they argue that in many cases these requests come from social death, of being deprived of the most basic and vital communications. The request to die means that, 'You have already deprived me of those relationships that give meaning to my life. Now you can take my dead body to bury'. These authors argue this is a last resort, a cry for help to persons important to the requester. The last line from Lyn Brown MP states:

... and yet I know that the mere existence of legal and assisted suicide would have placed an enormous burden on her —

mother —

But what of those without a loving family? (on the visual presentation)

The Auditor-General's report, indicating that most people want to die at home, would have some way to go to making sure that those who enter aged-care facilities do not feel either socially isolated or overly vulnerable. If the highest standards of aged care were always on offer, the fear of hospitals and aged-care places may not be as acute.

The first of the terms of references asks the committee to:

assess the practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they want to manage their end of life, including the role of palliative care.

The submission of the Catholic archdiocese specifically addresses this term of reference by endorsing legislation or regulations related to advance care planning that should respect the values of the patient, provide for the descriptive rather than prescriptive documentation of the patient's wishes and allow the patient to remain at the centre of life care, guided by professional support.

The need for greater education amongst health and aged-care personnel and the citizens of Victoria as to methods, efficacy and benefits of palliative care will require the department to roll out a comprehensive education and information package. As identified in the Auditor-General's report, palliative care services must be made available to all Victorian citizens. We comprehensively reject any need for a change in legislation to legalise euthanasia and patient-assisted suicide. We do not accept that the provision of palliative care is passive euthanasia, and we reject attempts to smudge the significant difference and intention of palliative care and euthanasia. Further, the refusal of overly burdensome treatment or futile treatment is not euthanasia either.

I have been privileged to be a member of three human research and ethics committees: at Bethlehem hospital in Caulfield for eight years, at Southern Health Dandenong Hospital for three years and at Melbourne Health for four years. As we speak today, as we sit here today, there are scientists, pharmacists and leading clinicians all working to develop the best medical treatments and medicines for the future. Today almost everyone can be cared for and have dignity until their natural death. Would legalising euthanasia and assisted suicide slow, cripple or even terminate the fantastic research that is going on across so many branches of medicine? Again, one of your colleagues in England, in the last line of the slide, tells the story of one of his friends:

I wanted to tell that story because it is not unheard of, given the pioneering research that is continually being carried out, that cures to many illnesses and diseases will be found, as I have no doubt they will.

Twenty years ago we had little to offer people diagnosed with melanoma. Today there are almost two dozen different care and medical options. We endorse the words of Dr Brian Pollard in his book on the subject of euthanasia, who writes:

It is a bitter paradox that euthanasia is being promoted primarily because of poor medical care at a time when we know better than ever how to care well for the dying. The medical profession has at its hands the best social answer to the call for euthanasia.

Dr Pollard continues:

By any criterion, it must be ethically superior to attend to the elimination of human distress before the elimination of human in distress.

He adds:

In any other sphere of human activity, if it were proposed that people in distress should be killed in preference to applying known and proven remedies for the relief of that distress, the proposal would be seen as grotesque and anti-human and would be universally condemned.

It has been argued in the media recently that a person should be able to determine when and how they will end their own life, especially if they are in extreme pain. One person has argued loudly that ‘if I am in unbearable pain, I should be allowed to make a request for a prescription after two medical practitioners concur, one of whom must be an expert’, but the expertise has not been stated. The proponent of this case excludes their family from the discussion. There are a number of flaws to this argumentation. It is basically saying that everyone has absolute autonomy, and that what I do with my life has no relationship with others. We submit that no-one’s life is absolutely autonomous. Every action we undertake involves cooperation and relationship. Every meal we eat is the result of a whole chain of cooperation and relationships. Every piece of clothing we put on this morning is part of a chain of cooperation from farmers and manufacturers to dry cleaners et cetera. Even the simple act of washing involves a whole lot of cooperation.

Proponents of euthanasia and assisted suicide might argue that it is my life, but no life is absolutely individual and it will always be lived in cooperation and relationship with others. Gordon Marsden MP said:

‘No man is an island’—

and no woman, for that matter. It has been suggested today that the decision that we make is simply for the individual. It is not simply for the individual ... (on the visual presentation)

When I die, two men will need to lift me onto a trolley and put me into the mortuary van. I will not even get from the hearse to the grave without four or six people to help. We are always involved in cooperation and relationship.

The proponents of euthanasia and assisted suicide will say that a person in sound mind should be able to swallow the tablets at a time of their choice. The proponents of euthanasia and assisted suicide are not simply asking for an individual to be able to determine their end; they are asking for a whole lot of other people to become involved in an end that is not the end-of-life care but the ending of life. While they say that only doctors and patients are involved, the death of anyone has its influence on others. But any request for assisted suicide and euthanasia asks the medical profession to cooperate in it. Andrew Denton, for example, recently said at the Wheeler Centre that doctors do not want to do it. Any request to change legislation to allow assisted suicide or euthanasia basically asks legislators to cooperate with suicide and to cooperate with those who would prescribe lethal medicine or administer lethal injections.

Any request to change the law is asking legislators to become cooperators. Your counterparts in the House of Commons in September overwhelmingly rejected the request to become cooperators in suicide and assistants in euthanasia. The submission of the Catholic Archdiocese of Melbourne, through which we willingly participate in the development of sound public policy, aims to promote the dignity of the dying patient, the care of the relatives and the widespread education as key elements in raising the level of genuine end-of-life care in Victoria. Without suitable, genuine end-of-life care options, people cannot manage their end of life, as the terms of reference of this inquiry state. Without suitably managed end-of-life care, the temptation is to end life care.

Chair, allow me to conclude by quoting from the last chapter of Dr Ira Byock's book entitled *The Four Things That Matter Most*. Byock addressed your task and our task:

We must rise to these challenges. It will take creativity, collaboration, and an unwavering commitment, but we can do it. As we care for our parents and as they die, we become the next generation in line to face the end of life. The models of care we build today will determine the quality of care we receive tomorrow. It behoves us to nurture forgiveness, gratitude, generosity, and love in ourselves — and model these qualities for our children.

We thank you for your attention, and we would be pleased to respond to comments that committee members may have, whether in relation to this statement or our formal submission. Thank you, Mr Chair.

The CHAIR — Thank you, Monsignor Ireland and Father Kerin, for that opening submission. Monsignor, can I take you to your suggestion that there is much medical research taking place around Victoria and other places at the moment that may see new cures for current illnesses that are terminal and other advances in medical treatment, and that that may be put at risk by some form of legislative euthanasia. Can you point to any of the current jurisdictions that have a voluntary euthanasia regime, such as Oregon, Holland, Belgium, Switzerland or elsewhere, where medical research has been put at risk? Can you establish any relationship between the reduction in medical research and the establishment of those regimes?

Msgr IRELAND — I think it is more the commercial side as to whether investors would be wanting to invest in medical research in curative medicine. If the option was to terminate people who are suffering, would medical research want to invest? Would the big pharmaceutical companies want to invest in pharmacy to cure conditions? There has been a little bit.

The CHAIR — I noted your evidence that there is a significant difference between palliative care and euthanasia.

Msgr IRELAND — Yes.

The CHAIR — I think one of the challenges for all of us, perhaps speaking personally, is to identify where palliative care starts and some form of euthanasia commences. We were discussing with the previous witness the situation that a patient may refuse PEG feeding but cannot refuse oral feeding. It is a very complicated question in a way, but are you able to crystallise where palliative care ends and, in the view of the church, where euthanasia commences?

Msgr IRELAND — I am.

The CHAIR — Excellent.

Msgr IRELAND — It goes directly to what our intention is going to be, and that is what you are asking me. What is the intention of palliative care, and what is the intention of euthanasia or assisted suicide? I noted in one of the other submissions that they said, 'This is a religious notion that goes back to St Thomas Aquinas' et cetera. It goes back long before that. It is actually in your court, Chair, and members of the committee, because it is legislative. When St Thomas is talking about intention, he is actually quoting the Roman jurists. He is quoting Ulpian and Seneca et cetera. He is quoting the legal system.

If I can just back-pedal a bit, you guys know that intention is important in all sorts of spheres. As parents you know that if your kid has taken something and you say, 'Have you taken something?', and the child responds and says, 'I was only borrowing it', what is the difference between taking — stealing — or borrowing? It is the intention. You know it in terms of the difference between manslaughter and murder. It is about intention. Similarly with palliative care and euthanasia, what is the intention? The intention of palliative care is to palliate, to relieve, the suffering. The intention of euthanasia is to take away the person who is suffering.

The CHAIR — I have what is perhaps an obtuse follow-up question. You said the origin of this document comes from the Roman jurists. We had evidence from a witness early on that that double-effect notion came from, I think, the crusades. That is not your understanding, Monsignor?

Msgr IRELAND — I was only saying St Thomas because St Thomas quotes the Roman jurists. I could not say anything to you about the crusades

The CHAIR — Sure. So it is a bit off the topic.

Ms SPRINGLE — We hear stories of people who live in countries where voluntary euthanasia is legal and it is an option. They say that many people find a lot of solace in the fact that they have an option, that they may have the medication that is required to end their life in their home. They never use it, but it gives them relief to know that there is choice, which is in direct contradiction to one of the slides you had of the MP who said it would have been a burden for her mother to know that that was a choice. Can I get you to reflect on those contradictions perhaps for us?

Fr KERIN — I think what we are talking about here is a social issue. Your committee is well named, and you are to be commended for this inquiry. It is a social issue much more than a legal or a medical issue. What we are talking about here is a community and society. In those instances, those jurisdictions, say, Belgium, Netherlands, Oregon and places where this is practised, we are talking about a very small group of people, less than 1 per cent of the people who die, but the impact that that 1 per cent choosing to die and then being eulogised and almost canonised by the media in that practice has its impact and effect on the whole social milieu of that country. We have seen that it involves a suicide contagion. We have noted, for example, since Oregon legislated that the standard suicide rate has increased remarkably and alarmingly. It is not yet the largest suicide rate in the US, but it is getting there, when Oregon had a very low suicide rate prior to that. There is that connection in the society. Where you find people with suicidal tendencies, or people who feel that their life is useless or painful or distressing, you will often get people in that distress making the decision and saying, ‘Where do I find comfort? Where do I seek release?’.

There was a recent article in the US about people suiciding off the Golden Gate Bridge. Something like 20 or 30 people have actually survived. A journalist went and interviewed them, and in every instance of the people that he spoke to he asked, ‘What were you thinking in those 6 or 7 seconds before you hit the water?’, and inevitably they would say something like, ‘I thought this would be the answer to my problems, but then on the way I realised that every problem in my life could have been solved, except that I have now jumped’. Inevitably people regret suicide attempts because they are not in that distressful moment that prompts them to make that choice. That is why I say it is a social issue. This is an issue for the whole of society. Every one of us bears a responsibility to reach out to care for people in that vulnerable position.

Ms SPRINGLE — That still possibly does not get to my point in that you talked about palliative care being about intention — all of it being about intention — and about relieving suffering. I suppose I am pointing to the fact that there are many cases where people who are very unwell have found having an option relieves their suffering. They do not take the option — they do not commit suicide, or how you are terming it to be suicide — but they actually find that having the option relieves their suffering. That is more what I am I guess asking you to reflect on.

Fr KERIN — I think what we are saying is that an alternative relief or palliation to people in that situation is to provide the care and companionship at that moment. My experience in reading the literature suggests that for the people who see the possibility of taking the pill it is a substitute for something that is not there in their life — some reassurance that they are not getting from their medical professional.

Recently at Box Hill Hospital we had a patient who, through diabetes, had had his leg amputated. He was feeling useless, and he was grumpy and upset and angry and depressed and annoyed, and the staff identified that. He was treating the nursing staff atrociously. One of our special carers suggested I go and see him. I spoke with him for a while. We talked. We talked about his life in Germany before he came to Australia, about all the things he had done, and I started to chat to him about how valuable his life was, about what he had done. Then I went back to the nursing desk and I told the nurse unit manager, ‘Do you realise how interesting this guy’s life story is?’, and the staff then started asking him questions and talking about it, and pretty soon he developed the fact that he would need help to get to the bathroom because of the amputation but that it was an opportunity for them to find out more about him and for him to share his experience with them, and he was suddenly feeling valued. The next week he was off to rehab and had the same experience there. People started treating the patient and not the symptom or not the disease. I think that is where it becomes very social.

This is a good example of rural care. On 24 April this year my mother passed away in Mansfield at Buckland House. Buckland House is an aged-care facility immediately adjoining the Mansfield hospital. My parents had been residents there for 20 years in the town. They knew the people — the nurses, the carers, the cleaners — everybody knew them. Mansfield is a lovely place. If you have ever been there, it is beautiful. It is a country

town where the publican, the barman, rang me up and said, 'I haven't seen your dad at the pub for a meal recently. Is he alright?'. I said, 'Actually, he is in hospital'. Where would you get that sort of care, you know?

Anyway, they called me in April and said my mother's days were nearing their end and asked if we would come, so we gathered the family together. She was in Buckland House being beautifully cared for. She had had dementia for five or six years. She had always been in a very happy place, although for people who did not know her, they might see her life as distressing. She has always been a pleasant, happy, joyful person, and even to the last moment she still had that joy. She was meeting new people every day; they were the same people coming back, but she was in a good space. They were caring for her, and they loved her. They held her hand when they fed her — all sorts of experiences like that. Then my father had a fall. He was in hospital next door. The staff gave us the door code to go between the two to take him over to see my mother, in a wheelchair.

Even with their limited resources, the care that the doctors and nurses at Mansfield hospital and Buckland House gave her was absolutely ideal as far as palliative care goes, because they were not treating her disorder, her disease. They were not treating just the pneumonia that was an onset with the dementia; they were treating the person and her family, and they were doing that because they cared, because they were a community. It does not cost a lot of money; it just costs a lot of care. Where people do that, palliative care experiences can be uplifting and releasing and cathartic for the family in dealing with their grief. Certainly that has been the case with my brothers and sisters and my father in coming to terms with my mother's death. It was a beautiful thing to be sitting around her bedside holding her hand in her last hours, as she drew her last breath — talking, conversing, seeing that she was listening. She could not speak at that stage, but she was hearing what was being said; her eyes were moving. That was an experience of being with her in a privileged moment.

As a hospital chaplain I get to do that regularly; frequently I am called in by the family to sit with them, to chat with them and to pray. Just recently I had a letter from a family who asked me to do their mother's funeral. She had been very involved with the church but had lost touch in recent times in her aged care. When I went in to perform the last rites, a woman who had been dead still and almost comatose suddenly made the sign of the cross. All of her daughters said, 'That is a sign'. Palliative care is about caring for people right up to their natural death. We do not want to delay natural death; we are not prolonging it or that sort of thing. We are simply treating people, caring for them, right up to their natural death.

Ms PATTEN — Thank you. That was a really beautiful story about your mother's death. Following on from the chair's questions about wanting to prolong life but not wanting to prolong death, I think that is part of palliative care; it is finding that line of relieving suffering. Dr Syme, who you are possibly not in agreement with, would suggest that by providing some medication that would end up causing death, he would see that he was doing that to relieve suffering, but the death that he may cause may happen fairly swiftly. Other doctors would say, 'By terminal sedation, we will relieve suffering'. That will inevitably hasten death, but it takes a much longer period of time because that person effectively dehydrates with no food and water. Can you explain to me how you can see the clear difference between those two doctors relieving suffering through a way that hastens death, but one is faster than the other?

Fr KERIN — I think it is a good example of correct decisions being made by well-trained and great practitioners every day. I see it all the time at Box Hill Hospital. I think it is also an argument to say that from the Grattan Institute report we can see that there are many people who are not well trained or not up to date in terms of good palliative practice, but those who do palliative care understand the distinction and the intention.

We have professionals who every day make the decision between manslaughter and murder; we have people who every day make the decision between this intention and that intention. That is their job. We have lawyers who do it every day. We have people in the hospital who are always weighing up, 'Are we palliating this pain, or are we actually killing the person, even unintentionally?'. So the strict monitoring of dosages and increasing the dose as the pain increases is fine; there is no problem with that.

What we are clear about, though, is that the person is dying naturally; we are simply palliating that process with them. I believe if there was much better knowledge and understanding about this, people would be far more comfortable with the whole concept of being able to make that decision. Certainly the professionals that I have met at Box Hill Hospital in the intensive care unit, in the emergency department and in the resuscitation bays do not have a lot of time in those areas for long discussions. But they know what I am on about, I know what they are on about and the families who are gathered around the person know that they are getting the very best of care and that everything is being done that we can do.

But death is a natural reaction to the end of life. As someone said: the human condition is a sexually transmitted disease with 100 per cent mortality. That is basically the situation we are in.

Ms PATTEN — So, Father, to clarify that, from the archdiocese's position, something like terminal sedation, which will certainly not prolong life but will not prolong death either, for you is not euthanasia; there is a line there.

Msgr IRELAND — We can fudge the terms when we talk about palliative care or palliative sedation and put in the term 'terminal sedation'. That is where the fudging starts to happen. Palliative sedation, as Father Tony said, is to relieve the pain. Terminal sedation would have the same or similar intention, so we have to be very careful about fudging the terms.

Ms PATTEN — I must say that when I ask doctors it is exactly the same procedure. Whether you call it palliative sedation or whether you call it terminal sedation, there is no difference in the procedure.

Fr KERIN — Except that doctors do sedate people. Induced comas are about relieving the stress while the body heals itself, and when you put someone into an induced coma, your intention is not that they will never come out of it; an induced coma is for the healing process. The intention is very clear. So we are not talking about the same thing. That is why we have to be very careful about intention and the purpose of why we are doing something. If our intention is to put someone into a coma to never come out of it, you can call that terminal, but that is not an induced coma as we would understand it in medicine.

Mr MELHEM — Thank you, Monsignor and Father. I understand where you are coming from in relation to assisted euthanasia or death versus the current system. I will give an example. The Netherlands is one extreme, which is basically Oregon, and then there is our current system. I just want to flush out, for example, if a patient has a directive plan saying, 'Do not resuscitate', where do you stand on that? Should that be respected?

Fr KERIN — One of the reasons we do not want prescriptive care plans rather than descriptive care plans is specifically for that point.

Msgr IRELAND — Because you cannot take every case, and a prescriptive plan cannot take developments or changes of mind into play. Rather, a descriptive plan would be a better plan to have. I have given the example in another place of an episode of *Stingers* on the TV a while ago where the young policeman had an advance care plan. He had cancer, but no-one knew it. He got shot on duty, and the people were going to resuscitate him et cetera. Someone rushed into the operating room and said, 'He can't be resuscitated, because he has a do not resuscitate plan'. His do not resuscitate plan was for his cancer care; it was not for his being shot. That is why we would advocate that people should have their wishes respected, but those wishes should be able to be amended, changed and developed as their condition changes, as medicine advances et cetera.

Fr KERIN — We support flexibility as presented by the Office of the Public Advocate. That sort of flexibility is what we would suggest.

Mr MELHEM — Another example would be someone diagnosed with cancer, they have three months to go and they refuse treatment. Surely that would be respected, or should be respected, by the family and medical practitioners. Where do you stand on that?

Msgr IRELAND — If treatment is burdensome — —

Mr MELHEM — Refusal of treatment, any treatment. It is terminal.

Msgr IRELAND — If it is an overly burdensome treatment, we would respect that request, but if it is a normal treatment that is not going to cause them burden, then that is them advancing their death.

Mr MELHEM — With that background, what would you change? You have seen the terms of reference. You have seen probably most of the submissions made to the committee, and I gave you the three examples — the Netherlands, Oregon and our current system. Is there anything within our system in Victoria, for example, that we should look at and change specifically? I know you have done that in your submission — —

Msgr IRELAND — Mr Melhem, if you go to the World Health Organisation website, they do not list euthanasia as a health treatment. They do not list suicide as a health treatment. In fact on the very first page they list suicide as something to be prevented. Allow me to quote. They say:

Suicide is the act of deliberately killing oneself. Risk factors for suicide include mental disorder (such as depression, personality disorder, alcohol dependence, or schizophrenia), and some physical illnesses, such as neurological disorders, cancer, and HIV infection. There are effective strategies and interventions for the prevention of suicide.

The World Health Organisation says that good health care is the prevention of suicide, not the advancement of it.

Mr MELHEM — Basically what you are saying to us is that what we have got in place now is basically working or requires further improvement, training, development and funding.

Fr KERIN — It can be improved.

Mr MELHEM — That is basically the view you will put to us of what we should be focusing on, not on the headline.

Msgr IRELAND — That is correct. We should be focusing on good palliative care and the education of medical practitioners, nursing and the wider community.

Fr KERIN — It is a conversation we need to have. It is really important that we talk about this, and when it is done well — as, for example, in the debate in the Commons — the whole community learns and becomes realistic about dealing with death. But if we were to introduce a line item in Medicare called Medideath, it just makes no sense. It is called Medicare for a reason. We do not want it called Medideath.

The CHAIR — Perhaps I will go to the same point that Ms Springle raised. Our discussion this morning has principally been around the hospital situation or the situation of palliative care. I am not sure if you have had the opportunity to read the evidence of the coroner, but the coroner gave evidence — and I must say, too, that it was just fact-based evidence, because the coroner will not give a policy position — of a number of horrific suicides of people who are not in the healthcare system

Msgr IRELAND — Elderly people.

The CHAIR — Yes, people who are perhaps elderly, and they have determined that they want to end their life. They have done so in often horrific, excruciating circumstances. I would be interested in the church's view of those situations and how they can be alleviated. Many of them do not come into the healthcare system. They are people who are of sound mind who make a conscious choice and are not suffering from depression or any of the things you cited from the World Health Organisation.

Msgr IRELAND — Chair, with respect to the coroner et cetera, the coroner can dissect the body, but he cannot dissect the mind of the person. When he sees the person, he sees them after the event, so we do not know what the intention of the person was. We do not know what their mental suffering was. We do not know what they have experienced on their last journey that has brought them to that point. Again, as I have pointed out, the World Health Organisation does say that 800 000 people die of suicide every year around the world. It is something that as a society we should be looking to prevent rather than encourage.

Fr KERIN — I can give an example of, three months ago, a parishioner very well known to me — a man who had been a great help in many instances. He used to pick up my car and take it over for a service and that type of thing. A retired gentleman and a craftsman, he worked with his hands. He was very skilful. He had an engineering background. His wife is a daily churchgoer. He felt that as arthritis was depriving him of the use of his hands, the things that were most important to him — being able to work with his hands, the dexterity — were disappearing. He felt that his antidepressant medication was too expensive, so he stopped taking it and then hung himself in the garage. He was in his late 70s. It was devastating for his family and for the community. He had sort of gone vague in the last few months leading up to it, but even his wife and children had not really picked up on it.

That is why I say we are talking about a social issue here. It is a social problem. No-one is immune to it. Even the best families are having this experience. But that is why it is important for us to keep saying that every life is

valuable. One of the things that really annoys me is the judgemental attitude of some of the people arguing for euthanasia who say, 'That life is not worth living. I couldn't live like that'. The judgemental attitude to say that because you are in a wheelchair or because you have got spina bifida or because you have got motor neurone disease, 'I could not live like that' — that judgemental attitude in saying, 'This life is not as valuable as that life'.

The difficulty I have is that as soon as we start to say that killing some people is okay, suddenly we have a group of people that it is okay to kill. This state took a great step forward when we decided we were not going to kill criminals. Why would we want to take that retrograde step? We are going to have to deal with suicide. We are going to have to deal with the social issues, but this is not the answer. Giving in and saying 'Look, it's too hard; let's kill them' is not the answer.

Ms PATTEN — Thank you. I have been looking at your positions on advance care planning. Obviously given your experience as a hospital chaplain you understand that conversation about dying and the fact that quite often we do not have that conversation until 24 hours before someone dies. In relation to advance care planning I note your section on freedom of conscience. In an advance care plan, we have heard from people who would have a plan that would say, 'If I have advanced dementia and I get pneumonia, I do not want antibiotics'. That would be in their advance care plan, and it would be something they had discussed with their family — 'That's just really prolonging my death, not my life'. But your position would be that if the doctor did not agree with that decision, the doctor could override that advance care plan under their freedom of conscience. Am I correct in that reading?

Msgr IRELAND — You are.

Ms PATTEN — So the advance care plan could always be overridden by a doctor if they did not agree with that individual's plan?

Fr KERIN — A doctor is pledged to do what is in the best interest of the patient.

Ms PATTEN — If that patient says, 'I don't want an antibiotic' — —

Fr KERIN — Just because people request something does not mean it is in their best interest. We have people in this state who are requesting ice every day; we do not give it to them — or we try not to.

The CHAIR — Father Kerin, I go back to the discussion we were having before and your proposition that state-sanctioned or the active state killing of people, to paraphrase you, is not to be condoned or endorsed. What about the situation that exists in Oregon where it is self-administered medication, or however you want to describe it, that leads to death? There is no actual participation by a doctor, save and except for the provision of the medication. Do you want to respond to that?

Fr KERIN — I think we are talking about the fact that people who are suicidal and want to kill themselves find a means somehow. The difficulty with organisations like Exit and the tragedy that arises in their wake, particularly when you speak to the families of these people, is more than evident. The literature is all there, so I am sure you have heard about the difficulty.

What is not really being recognised, though, is that the suicidal attitude or propensity is often accompanied by mental disturbance and distress, and that is not always checked — even if you look at the figures from Holland of 800 people. A psychiatrist was only called in 6 of those cases of 800 people who were medically assisted to suicide. They are not recognising the mental distress. They are fine identifying the physical distress that the person might be in, but they are not always recognising the full mental picture around it.

The CHAIR — Do you accept that someone who may be in such excruciating and sustained pain that cannot be palliated may have mental capacity and, save and except for the pain, they do not have mental distress? We have seen submissions and heard evidence from people in some well-publicised situations where people have perhaps decades of what I think most people would agree is insufferable or sustained pain that palliation cannot address. People are not perhaps in the sort of scenario that we have been discussing today.

Fr KERIN — Yes. I am not able to speak with medical expertise; I can only talk about the spiritual or pastoral caring with patients. In my experience palliative care needs to start a long time before the last 24 hours. In fact often when an elderly person has a fall and is admitted to hospital it can be the beginning of that path.

One of the benefits we have with a strong spiritual care department, as Eastern Health provides, is that people are able to engage in and begin a conversation early on. There is nothing wrong with praying for a happy and a holy death; it is something that often accompanied the saints.

When you look back at some of the experiences of the families: how do we want to die? Have we ever asked ourselves that question? Do I want to die in a bed with all my family gathered around? Do I want to have made my peace with various people before I do that? Beginning that sort of conversation early on enables people to break through the moments of pain, because pain is always a transitory thing. It comes and goes; it is never just a constant. Because it is being treated or medicated, it comes and goes as the medication waxes and wanes. You have got a situation where many of these things are transitory, and it depends on whether you catch someone at a good time or a bad time, on a good day or a bad day. That is why we are keen to be descriptive rather than prescriptive in end-of-life care.

Msgr IRELAND — This might address Ms Patten’s question earlier. I will give a homespun example as well. At Caulfield Hospital when my mother was dying they called my sister and me in on one Sunday afternoon and they said, ‘We can do no more to keep her going. We’re going to begin palliative care’ et cetera ‘and you can expect her demise shortly after’. The palliative care actually relieved her pain such that she sprung back in about four or five days and then was able to have curative medicine for her condition and lived on for a bit more. She went in and out of palliative care a number of times towards the end of her life, but, as I say, the first time when they said, ‘Expect the end because she is going to palliative care’ was not the end.

The other thing that I would like to say to you is the *Economist* recently had a publication about end-of-life care, and Australia is right up the top, is it not? It is at no. 2. We have got the best end-of-life care, and we should be proud of that. We should be proud of our achievements, but we should also be building on the quality of life in Australia and the quality of end-of-life care. We also have one of the longest living populations in the world. There are 14 countries in the world where people do not live to 50. There are hundreds of thousands of people across the world today who will die of hunger. There are hundreds of thousands of people who will die today because they do not have potable water. Some of our discussions are discussions that can only happen in an advanced society, in a wealthy society, and we also need to keep in mind some of the other parts of the world where people will die without palliative care, without modern medicines and in conditions that are far inferior to what we experience in the state of Victoria and in this country.

The CHAIR — Monsignor Ireland and Father Kerin, thank you both very much. It has been a most informative discussion, and we do appreciate and thank you for your submission and your preparedness to be with us today.

Msgr IRELAND — Thank you.

Fr KERIN — Thanks very much.

Witnesses withdrew.