

# TRANSCRIPT

## STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

### Inquiry into end-of-life choices

Geelong — 29 July 2015

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Mr Jason Trethowan, Chief Executive Officer, and

Dr Ric Milner, General Practitioner, You Yang, Western Victoria Primary Health Network.

**Necessary corrections to be notified to  
executive officer of committee**

**The CHAIR** — I welcome Mr Jason Trethowan and Dr Ric Milner. Thank you, gentlemen, for being here this afternoon.

I will just caution before we start 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. Transcripts will ultimately be made public and posted on the committee's website.

We have allowed 45 minutes for this session, so I would invite you to make some opening remarks, and the committee will have questions thereafter. Thanks again for being here today.

**Dr MILNER** — We are both from the primary health sector. Jason is a leader in the primary health sector and I am a general practitioner with, because I am old, a lot of experience in palliative care and home-based care. My background was I worked in a sexual health clinic and looked after a large number of people with AIDS in the early days and was exposed to lots of requests for assistance in death. Some of them still make me distressed even talking about them. It was a pretty torrid time in those days. Fortunately now the medications are better and it is better, but the same issues still occur in other illnesses. I am hoping that this committee or this group would not be focused on euthanasia as a problem, because it really polarises people and does not result, in my view, in moving to help patients have better end-of-life experiences. I think we should be focusing on removing, or reducing, dysthanasia rather than euthanasia, so removing distress or reducing distress in people's end-of-life processes.

It is true — and I am sure you have heard this before; you have asked a lot of people — that there are some practitioners who might be terrified of legal ramifications for easing suffering. Most people who do it a lot are not, but some people are, and that can result in increased suffering and distress for people with end-of-life problems. I think it would be a lovely thing if there were something that came out of this that there was a statement from the government, or from the Parliament, that easing suffering is a noble aim and that people who ease suffering are not at great risk from the law provided their aim is to ease suffering.

Having said that, the majority of things that need to be done to improve people's end-of-life experiences are fairly basic, pragmatic things. They are not highly ethically difficult things. They are practical things, and one of the biggest problems we have is that primary health is not well connected, particularly in communication, to secondary and tertiary health. This region is much better than most, largely because of Jason's work with Barwon Health — the organisation that we are a part of has a great partnership with Barwon Health. And this area has progressed. For instance, you will have heard from Jill Mann this morning about the Respecting Patient Choices program. If you look at their numbers of people who have had that, it was pretty much a flat line until there was a partnership with general practice, and that resulted in the biggest number of people having their advance care directives achieved in Australia, by far. If you look at the completion rate, the completion rate of those advance care plans is much higher when it is initiated from general practice.

As you heard — I was listening to the previous people — they were describing how a relationship improves the process. People hopefully have a longstanding relationship, if they have severe illness, with their general practice. Not just the doctor but the nurses and physios, and they are more comfortable usually in discussing some of these difficult and fraught areas.

In the initial project that we did, there were 100 patients in my practice that I did just as they walked in the door. We talked about it, I had been talking about it for 25 years but there was no documentation of that, and often they would go into hospital having plans about what they wanted and then it would just go astray because there was no documentation of their desires. Since that process has begun, those desires are now documented in Barwon Health.

I have an advance care directive. If I fall off my bike and I am unconscious, the screen opens up and it tells them who my medical power of attorney is and what my desires are, not in terms of treatment and what treatment I would have or would not have but what outcomes I would not tolerate. I think that is a process that avoids dysthanasia. So if I was severely injured and the unlikely outcome for me was going to be that I could never

walk or talk again, then I would not be accepting certain medical treatment and my medical power of attorney would stand in and push for that. We need to get that culture that that is accepted.

When we have talked about this in the past with some people from the secondary and tertiary sectors, they put up some objections like, 'What if I happened to choose a psychopath as my medical power of attorney?'. There is a sort of paternalistic view that people need protection from their decisions, and I think that is really dangerous and wrong. If I make a decision and I choose a psychopath, I have to wear the consequences of that. It is just like marriage: if you choose a partner, the state does not tell you that you have made a bad choice, and I think the same thing should apply with advance care plans. I would like to see, as part of our culture, that this is not an extraordinary thing done for a small number of people, that it is done as a routine thing.

It would best happen if it were driven from primary health, because if you suddenly get a severe diagnosis and you are suddenly thrust into a treatment stream, it is not a great time for reflection about what is important to you in your life, because you are under duress and making decisions under duress. These are decisions that are best made with time and a relationship in primary care. At the moment, though, it is not funded. It is not a state jurisdiction, but the state could push for an item number for advance care directives, and that would make, I think, a big difference. The other thing the state could do is push for improvement of transmission of information. Victoria is pretty good but it is not good enough, and this region is probably better than most, but it has a long way to go.

The only reason it is better is because there is a relationship between primary health and secondary health. We have an advantage in Geelong in that we are big enough to be city and small enough to interact. The communication standards here are higher than in Melbourne, and my colleagues are in awe of what we can do here, but it is still nowhere near good enough. If the state was to say that all public hospitals have to transmit any advance care plan to every other public hospital, that would be a start. If all information that is transmitted is transmitted electronically in a language that can be deciphered by the private medical software that all the general practices have, that would be a start.

I have had patients who have walked in the door and I have not seen them for three months and I have had two bits of correspondence from the tertiary sector, particularly if it is from out of Geelong, so that is really poor and needs to be improved. That is important in delivering better outcomes for people in the end stages of their lives.

One simple thing that could be done concerns palliative care nurses. I have a patient. When I leave here today I will be seeing this lady. I will go and see her. I write a script when she first comes home for a bucketload of narcotics and other drugs to be kept in the house — a range of them. If I go to another palliative care person, I will write another bucket full, so there are bucketloads of these drugs all around the place, mostly not being used, because the palliative care nurses are not allowed to carry the drugs. If the palliative care nurses had a bucket full of a bigger range of drugs, they could then ring us if they needed to alter doses and things. They used to do it many years ago, but there was a palliative care nurse who was using narcotics herself, so they just wiped it. That sort of protecting the organisation structure just causes discomfort and harm to patients. That would be an easy thing to fix — to just make it that they can and should.

The private sector is often isolated, so we often make a diagnosis of bad disease and they disappear into the public sector. They have had a relationship with the private sector physios and all these other people until they are in the public sector, and then they come out and those relationships are not encouraged or re-formed. We need better coordination and use of the private sector, but particularly if relationships have started.

If I go back even further, one of the problems with very highly specialised medicine is there is not an overview of whether something is sensible. Often with highly technical medicine 'Because you can do it, you will' is part of the culture. I do not think they are being mean or anything; it is just that that is part of it. Sometimes not embarking on a process can be suffering reducing. There is a lot of time and effort spent on fairly fruitless treatment with low chances of doing anything and high morbidity. If you have a connected general practice, the patient comes to see me and says, 'They are going to do this, this, this and this'. It is third-line chemo. Sometimes in having a relationship with them you can bring up, 'Is this really what you want to do?'. You can expose that in a more experienced generalist way, and they will often go, 'Oh, I didn't know that it was not going to work that well'.

Some of the language that is used particularly in cancer treatments but also in cardiology is a little patient blaming. For instance, they will say, 'The patient failed the therapy' rather than 'The therapy failed the patient'. You will see someone's scan and two of the big cancers have shrunk a bit, so they will call it 'a partial response', while the other five have grown, rather than a bit of clear language. It is partly because they do not have a relationship — this is my view — in that they are a bit scared of frightening the patients, whereas we can have a more brutal, if you like, connected conversation because we have a relationship.

In summary, I would like to see the pragmatic things that make general practice and physio and OT and all that stuff connect better with the secondary and tertiary sector, and remove as many obstacles of process to that happening.

There is one other thing. Today I am going to see this person to write up some different drugs because the nurses have rung me. If I had telehealth, the nurses could flip up the screen and I could do the stuff at the time. Rather than a fax coming in, it could all be done. But I would need to have an item number to make that work. The federal government did have this program for telehealth with item numbers and huge amounts of money for regional areas. We do not want that. We just want a standard consultation. We will pay for the equipment. What we want them to do is to say, 'That is a standard model number', like it is face to face. At the moment there is no fee for that, and if that were happening, then patients would not wait for me to go and see them. They would see me with their nursing staff at the time.

**Ms PATTEN** — And just Skype in or something.

**Dr MILNER** — Yes, and there would be a three-way discussion and we could fix it. But that will not happen unless there is a fee. That is just the reality of the world.

**The CHAIR** — Thanks very much for those comments.

**Mr TRETOWAN** — I will add a few points and probably endorse a few of what Ric has already mentioned. If I could just take a bit of a broader look at this inquiry and the relevance to a primary health network and the relevance of out-of-hospital care services and the linkages that Ric has already outlined in terms of links from primary into secondary and tertiary care, it is fair to say that in the health system itself we often are very good at asking for more and are not very good at seeing something being taken away from here and being placed over there, or the redistribution of funds. The health system has it down to a fine art in terms of trying to advocate for more and is not happy when we receive a cut, whether it be through government decisions or other.

The reason I raise that particular point is that an opportunity arises around the federation health white paper being developed, obviously, through the federal government and its recognition that effectively the greatest gap in the health system is the system itself. We will always want more clinicians, but more will not always equal a better outcome for patients. So the role of a regionally based organisation that is well connected to local communities, to members of Parliament, to mayors and councils of local government areas and also to the health system itself — primary, secondary and tertiary care services — is that they will be best equipped over time to make the most effective and efficient decisions for that community. They will be more targeted in their decision-making. The allocation of resources will be far more effective than perhaps by those who are sitting in head offices in Canberra or indeed in Melbourne.

The reason I say that is that this is a classic complex issue that really is symptomatic of why the system does not always work for people. We acknowledge and celebrate in Victoria that the health system is pretty good. It is good for a lot of people, and it is good for a lot of clinicians — really good for a lot of clinicians — but it is not terribly effective for a lot of people who are not as well connected to the health system or who suffer from poor health literacy. I heard you talking before about people in our community from culturally and linguistically diverse communities and our Indigenous population. I refer to those who are not part of mainstream primary health care services — for instance, 87 per cent of people in this region would go to their doctor once a year. Of those, they will come back five and a half times. One in 10 people in this region will visit a hospital each year. More people will go to pharmacies. More people will go to optometry clinics, the private physio et cetera. There is no shortage of access to health services; it is just that perhaps there is a maldistribution or there is an inefficient way of actually getting through to those services.

When we have complex scenarios like the ones we are discussing today, the state government has an enormous opportunity not to sit back and say, 'Well, we're waiting for an item number in the MBS change', which we know was fairly difficult to come by at the best of times for a change in that area. You have an enormous opportunity to recognise what the federation health white paper is actually describing, and that is that the system is broken because of poor collaboration between state and federal governments. The blame game continues. The poor relationship between health departments continues. There is no bilateral agreement in primary health care between what state and federal governments have together in this state. Unfortunately, as a result of that, we see that as very important because what it actually does as an outcome is promote fragmentation in the health system.

Typically, then, a response will be that the state will bunker down and try to solve things within what is in its control, and largely that is through the mandate of the provision of public health services, but also in recognising that there is a strong role for an interface with general practice and the broader primary healthcare system. But way too often the decisions — and this is why I welcome this inquiry — or the empowerment of the direction will often miss the community voice and will often be biased by secondary care providers who will have great intentions but may well not understand because they have not lived the experience of working in primary health care. They are not the ones who are seeing 87 per cent of the population each year and repeat attendances following that. From my point of view I hope, if anything, this inquiry not only addresses the concerns that Dr Milner has put forward, but also recognises the principle of subsidiarity, with decision-making being devolved to the most effective level, and we would argue that is in regions.

Western Victoria is our new region for our primary health network, unlike previous iterations of Medicare Locals where they were obviously closer in communities. From our point of view the change is that there is greater opportunity now to ensure that people in rural communities, who perhaps have had an advance care plan — say, in Port Fairy, and then travel down to the Geelong Hospital, where they unfortunately come under a circumstance where they end up in an acute setting — can have their advance care plan available to the clinicians at the point of care.

I can assure you that in most cases that will not be the case. Clinicians need access to information at the point of care so they make the best decisions not only in a clinical sense but also in the context of what the patient wishes, and respect the choices that the patient has consciously made many years ago, or even many, many years ago. The state government has an opportunity to realise the capacity of a system that historically it has had very minimal control over — in fact it has had no control over — but now can have a relationship role. A way in which you can improve that is certainly by cutting through the nonsense of relationships between state and federal government in the interests of communities and back regions to come up with innovative ideas. Policy context is exceptionally important for a state government — do not get me wrong, because you are allocating public service into directions. But your funding will be way more targeted and effective — and I will throw in the word efficient again — to promote access to quality health services where and when communities need them, and also bridge the gap between rural communities' experience and more urban environments in a Geelong or a Ballarat context or indeed in an inner Melbourne context.

I reiterate the point that many of the topics you will talk about will be in relation to the mainstream community, but in fact you are addressing it — which is great to see in previous discussions as well — and looking it from a point of view of whether they are rural, Indigenous or CALD communities. For the state government to recognise the opportunities that you have now in a policy context in addressing the issues that Dr Milner has raised and others will today, having a well-connected system is going to increase opportunities for improving outcomes for patients. An outcome for a patient is often not necessarily keeping them well; it is supporting end-of-life care in the way in which they have requested. That concludes my comments.

**The CHAIR** — Thank you both for your comments to the committee. Dr Milner, I would like to follow through your comments — without putting words in your mouth; tell me if I have got this wrong — that some, probably not most, doctors still have concerns about the legal parameters when administering pain relief and other types of medication to patients. Could you talk in further detail about that, because obviously that is one of the issues?

**Dr MILNER** — Some do. It tends to be either particularly inexperienced or younger doctors who have come into the system and who are terrified of the risk, for instance. They struggle with making risk judgements. They might ask, 'If I relieve someone's suffering and I give them some stuff that sedates them or something and

their respiratory rate goes off, what am I going to do? Is that an acceptable aim to do that?'. They are reluctant to take that albeit small risk, so they will allow that person to have some distress which they might not have because of the risk of that process. If they have had prior discussions with the patient, that risk can be discussed, so the patient can make that call. The doctor might ask, 'What would you like me to do if you have this pain? I can give you some stuff and it might sedate you enough that you might have a respiratory arrest', and the patient might say, 'Go for it. I am happy to risk that. I don't want to suffer like that'. That risk is not small, but some doctors would be concerned that they would be seen as killing that patient, which they are not. If the patient is going to die very quickly, they are relieving suffering. That is not a very common thing, but you do get some resistance to that.

I have had that when I have taken my registrars around and I have seen someone and I have given them a fairly decent sedative dose of something to ease suffering. Nothing happens, but they are anxious that something might happen. If something does happen — there are side effects for driving. You have car accidents, but you do not just not drive, and you do relieve suffering. But there is some concern about the impact of the law on them, and I think you would have heard that from some of the palliative care people in the past. A statement saying that is a noble thing to do would be good.

**The CHAIR** — Or some clarity in the law.

**Dr MILNER** — I do not know how you can get that — I am not a lawyer — but some process that improves that. But that is not a major issue; the connectedness is by far more important than that.

**The CHAIR** — I am interested in your comments as a general practice talking about the centrality of general practice in this process, because that is something we have heard from others but not from a general practitioner such as yourself. It would appear from the evidence we have heard thus far that, as you have said, the general practitioner has the relationship and therefore has a key role to play.

**Dr MILNER** — That is true, but that relationship drives the efficiencies and drives the — you cannot do the advance care plans, for instance, without that being connected. I can have the best relationship with my patient, and nothing will happen if that is not transmitted into the tertiary and secondary sector. Yes, the relationship is vital and, yes, there is centrality, but often patients are excised from it, and you do not see them for — if someone has a really difficult illness, they might go into the Alfred and then go here and there, and then 18 months or two years later they are spat out and then we pick it up. Often we do not know where they are up to, what decisions have been made or what the plan is. So that is not well coordinated. In the very terminal care bit, then suddenly you have got a request to write a truckload of drugs as an administrative process, because the nurses cannot carry it. So you are writing things, and you are not sure why this is happening. It is not very good, so we need to be involved more often.

In this region we have general practitioners inserted into some of the clinics. It is better than nothing, but it is not enough. It has been a longstanding and difficult-to-fund process. Jason has got some ideas about that, but we need to think that through to get that to be more efficient and to keep that connectedness going through the acute phase of their illness.

**Ms SPRINGLE** — To clarify, you have both talked a lot about the connectedness, the communication and the integrated approach to different areas of the health sector. Are you talking about an IT solution? Is that what you mean? Logistically, what is your vision for that?

**Mr TRETOWAN** — It is typically referred to as an eHealth solution, so you are right; it is an IT and healthcare solution. It is around a couple of things. One is around the transferability of the information that is critical for the next clinician to understand information, like allergies or alerts. They are often there at the point of care. What it comes to in advance care plans? Yes, we are referring to that. If a hospital or a GP clinic in a rural community shares in a decision with their patient, that should be accessible at the point of care of any tertiary institution or other hospital in the sector.

The federal government, through what it refers to now as its My eHealth Record does have some developments in that space around having access to advance care planning information. It is probably slow. Now the issue with that system is that it has been opt in; therefore only a small percentage of the overall Australian population has it. Now they are going through a two-year process to look at opt out, and we already know opt out works, but we will wait another two years until that comes through and is evaluated. So, yes, it is very much around an

IT solution but one which the region itself can take some control over in the absence of any commonwealth or state leadership in that particular space. But I would argue that across Victoria it will be left to regions to work it out themselves.

**Dr MILNER** — It is fine if I fall off my bike here and go to Barwon Health, but if I wind up at the Epworth in Melbourne, I have not got an advance care plan in Melbourne; I have got one in my pocket — a little card — but I have not got a plan. In this day and age that is just not good enough; that should be transmitted easily across the private and public sector. With the advance care planning itself the actual process of the documentation is important, but the main part of it is that it encourages the conversation.

The conversation with the patient is important, but the conversation with the patient, their family, their loved ones and their carers is vital because that reduces end-of-life distress for their families. It is bad enough having your loved one going through terrible illness, but if the decisions have been pre-discussed, you have much less chance of two warring factions of children or relatives fighting over the decision that the person has made. I have seen that lots of times, and you see it less if there is an advance care directive because part of it is going to your family and saying, ‘This is what I won’t tolerate, and these are my decisions’. Then if you appoint a medical power of attorney, that person has the obligation to push for your decisions to be respected. The bit of paper is important, but the discussion is vital.

**Ms SYMES** — You were talking about the 100 patients that you have done advance planning directives with, and I think you are saying that with most of them it was a conversation you had after 20 to 25 years of treating them. What is the trigger for you to encourage someone to consider a directive? Is it age? Is it illness?

**Dr MILNER** — That project was opportunistic. It is just part of trying to get the connection right. There was a meeting. Then I spoke to Jill Mann, and we decided we would try to do this from general practice. I had already annoyed them enough about saying it should be done in general practice, so we got some funding from Barwon Health mainly and a little bit from us, and we did a pilot with me and another doctor. The thing that would trigger that would be if I was bored taking their blood pressure, because that is pretty boring, I would start talking about, ‘Have you ever had a relative, for instance, who has had a death that you thought was hard work for you, and how would you feel, what would your wishes be, if you were in that situation?’, or just bringing it up. Often you had had that conversation before, and I would look through my notes and there would be some comment about it — not old people necessarily, but someone whose mother had died recently. We have all been in touch with people dying. There are opportunities to do it, but particularly if they are over 75, their risk of death goes up then. If they have had friends and relatives die, they are quite keen to talk about it.

**Ms SYMES** — Do you think everyone should have an advance directive, regardless — —

**Dr MILNER** — Absolutely. Say you got to 40 — pick a number; it does not matter — when that was a rite of passage, that would be fantastic.

**Mr TRETOWAN** — As the option for.

**Dr MILNER** — I would make it compulsory.

**Mr TRETOWAN** — Would you? Okay, I stand corrected.

**Ms PATTEN** — Opt out.

**Dr MILNER** — Yes, but it needs to be a community conversation about what people want at the end of their lives. You ask people about what they think about going into nursing homes. Do they see that as a life they would be prepared to live? Most people do not see it as a great outcome; they would rather not be in a nursing home. They can put in place structures which would make their time in a nursing home less if they wished to — for instance, before they were demented. When I did my advance care plan that was my great fear, because I have seen it, so I put in that if I am dementing and I do not know what is going on, please do not give me flu vaccine, and please do not give me antibiotics for anything. I also put in mine that I would expect the doctors and nurses to grasp every opportunity to allow me to exit quietly. That is not getting them to kill me. They are my wishes, and my medical power of attorney has discussed that with me. He cannot wait, he said.

**Ms PATTEN** — He is a psychopath. That was not my question! Thank you both. It does seem to me that there that there is this solution out there that we are on the verge of, and coming down here today and seeing the integration that Barwon Health and you guys down here have done is really exemplary. I first got involved in this area during the time of HIV and AIDS as well, and I remember a friend having ‘Do not resuscitate’ literally tattooed on their chest to ensure that their wishes were met. And they were — sadly or fortunately. I know you are saying we should not bring up voluntary euthanasia because it polarises. In your advance directive you are saying, ‘If I can’t walk and talk, then I don’t want you to fix me’. Again, it is always this talk about refusal of treatment, rather than anything proactive. So, again, if you are in a nursing home, you are going to sit in that nursing home until the flu hits you or a strong stomach bug hits you or something else hits you. Is that the best we can do?

**Dr MILNER** — I think so, because that will not be long. I think that is elegant. You have to get the aesthetics right. I watched a thing about somewhere in Holland where some guy had some illness which was going to occur in five years time. He drove his motor bike up and then went and got the needle stuck in his arm. There is no problem with the morality of that, but the aesthetics are hideous. I think you have to have the aesthetics right as well as the law right. Dying has to be done in an aesthetically acceptable way as well as a kind way and as well as a self-directed way.

**Ms PATTEN** — Yes, I take that. I think you can also look at somewhere like Oregon where the model is quite different to the Netherlands. There they say that less than 1 per cent of people actually follow through with a physician-assisted suicide.

**Dr MILNER** — The discussion is important.

**Ms PATTEN** — But having that choice there enables the discussion and possibly improves the overall palliative care and the overall quality.

**Dr MILNER** — I looked after a wonderful man who asked me to kill him. I said ‘Why?’ and went through all the processes of why. He had all these terrible things happening with him; he had pain here and pain there. I said, ‘Look, can you just give me three weeks of having a crack at trying to improve stuff, and if you want to at the end of three weeks, what I will do is just withdraw everything, give you some more sedatives and that will be it. But give me a crack at it, and at the end of three weeks we don’t have to have this degree of brutal conversation. This is hard work for you and me’. It still is.

**Ms PATTEN** — Give me a safety word or something.

**Dr MILNER** — Yes. I said, ‘You just have to give me the nod’. He had people operating on his arm to relieve the pain. We did a whole lot of things. He had better nursing care with palliative care — a whole lot of stuff. He was a young man of 45 with kids. At three weeks I went to see him. He was sitting up in a wheelchair having a beer and a fag. He was back in the chair like this, and I said to him, ‘God, I thought you had had a stroke or something’. I said ‘What’s wrong’. He said ‘I’m just too scared to nod’. He lived for another year.

**Ms PATTEN** — But he knew he had that choice, didn’t he?

**Dr MILNER** — Yes, but I was not going to stick a needle in his arm. We were going to withdraw and sedate him, make him more comfortable and what happened would happen. It would still be aesthetically pleasing, not brutal.

**Ms FITZHERBERT** — I wanted to thank you for the really practical and insightful testimony you have given today. I found it really useful, and I think others will have as well. I wanted to ask about some testimony you gave earlier regarding palliative care nurses not being able to carry drugs and just get an understanding of the framework around that practice. Is that a legal requirement, or is it a hospital policy, or is it both? When you said this is something that could be corrected, what would be the specific correction?

**Dr MILNER** — You are the politicians; I just want it fixed. I do not know.

**Ms FITZHERBERT** — I want you to tell me how.

**Dr MILNER** — I suspect it is an insurance problem. Do you know the reason?

**Mr TRETHOWAN** — No.

**Dr MILNER** — I suspect — my belief is that they used to be able to, and then something happened, as I said before. Then they said, ‘We can’t do this — to protect us and the nurses. We’ll withdraw it’. I think it was a silly decision. I do not know whether is legal now or illegal, but that could be fixed. It is just a matter of saying, ‘This needs to happen’ and making the laws or the directives to make it so.

**Ms FITZHERBERT** — Does everybody use that practice?

**Dr MILNER** — As far as I know. One of the advantages of primary care is that we can cut to the chase more quickly. We have far fewer processes, so we can make judgements. That is our Achilles heel as well. We can make judgements, go into the home, see the person and do things more quickly with less process. For instance, if I go into the home, I do not have a form to fill out about whether they have got dangerous dogs, firearms — all that stuff. So we can be a bit quicker and more seamless.

**Ms FITZHERBERT** — I understand. A similar issue came up this morning, talking about who handles different classes of drugs and when, and that that can be a practical problem in terms of nursing people in the home when they are at the palliative stage. Do you have any observations on that issue? You were talking specifically about nurses being able to carry drugs around, and I assume you meant between homes.

**Dr MILNER** — Yes.

**Ms FITZHERBERT** — But the testimony that was given just before is that, as I interpret it, people can be prescribed drugs, and they can be kept in the home and administered by pretty much anyone.

**Dr MILNER** — That is right — and stolen by their nephew.

**Ms FITZHERBERT** — Yes.

**Dr MILNER** — The idea that the current process is safer, I think, is flawed. It is better to have one pile of drugs moving around. You still need some in the home for family administration, but you do not need to have a backlog of just-in-case drugs. The just-in-case drugs can be with the palliative care nurse.

**Ms FITZHERBERT** — That is a good point — practical.

**Ms PATTEN** — Jason, are you putting in a submission to us as well?

**Mr TRETHOWAN** — We can, yes. I think after this discussion we certainly will.

**Ms PATTEN** — Thank you, because I think that larger —

**Mr TRETHOWAN** — Contextual stuff.

**Ms PATTEN** — contextual area, which you have only had an opportunity to touch on, could be helpful in trying to trying to create this practical, common-sense solution here.

**Ms SPRINGLE** — I would agree with that, and if you do, I would encourage you to unpack some of those issues a little bit in your submission.

**Mr TRETHOWAN** — Sure.

**Ms SPRINGLE** — I think that would be really helpful.

**Mr TRETHOWAN** — We can do that. That is fine.

**Dr MILNER** — One of the reasons things are better connected here is because Jason pushes pretty hard.

**Mr TRETHOWAN** — It is my job, Ric. We do not want to say this region is special; it is not. I think regions are special.

**Ms PATTEN** — Yes.

**Mr TRETHOWAN** — I do wonder at times how public servants, as well intended as they are, can say, ‘I have made the most accurate decision in a central location’. What we offer is community connectedness, as much as we possibly can, ideally bringing the consumer voice to the table and bringing a clinical voice together with that. We can certainly tease out some of those practical examples.

**Ms PATTEN** — We have hundreds and hundreds of submissions from consumers.

**Mr TRETHOWAN** — Yes, no doubt you would have. We will bring a health system perspective, possibly from a different angle.

**The CHAIR** — Just for your information, the committee resolved to extend the date for submissions till the end of August.

**Mr TRETHOWAN** — Thanks, Edward.

**Ms PATTEN** — Now there is no excuse!

**Mr TRETHOWAN** — I will get my homework done. No, that is good. We will be more than happy to provide something for you. Thank you.

**The CHAIR** — Great. Dr Milner, Mr Trethowan, thank you both very much for your insightful contributions this afternoon. It is much appreciated.

**Witnesses withdrew.**