

# **JOINT SELECT COMMITTEE ON END OF LIFE CHOICES**

**INQUIRY INTO THE NEED FOR LAWS IN WESTERN AUSTRALIA  
TO ALLOW CITIZENS TO MAKE INFORMED DECISIONS  
REGARDING THEIR OWN END OF LIFE CHOICES**



**TRANSCRIPT OF EVIDENCE  
TAKEN AT PERTH  
THURSDAY, 8 MARCH 2018**

## **SESSION SIX**

### **Members**

**Ms A. Sanderson, MLA (Chair)  
Hon Colin Holt, MLC (Deputy Chair)  
Hon Robin Chapple, MLC  
Hon Nick Goiran, MLC  
Mr J.E. McGrath, MLA  
Mr S.A. Millman, MLA  
Hon Dr Sally Talbot, MLC  
Mr R.R. Whitby, MLA**

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**Hearing commenced at 5.08 pm**

**ARCHBISHOP TIMOTHY JOHN COSTELLOE**  
**Catholic Archbishop of Perth, examined:**

**REVEREND Dr JOSEPH PARKINSON**  
**Director, LJ Goody Bioethics Centre, examined:**

**The CHAIR:** Welcome to you both. Thank you for taking the time to come and speak to us today. On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the end-of-life choices inquiry. My name is Amber-Jade Sanderson. I am the Chair of the joint select inquiry. We also have Mr Simon Millman; Hon Dr Sally Talbot; Mr John McGrath; Dr Jeannine Purdy, our principal research officer; Hon Nick Goiran; Mr Reece Whitby and Hon Robin Chapple.

The purpose of today's hearing is to discuss the current arrangements for end-of-life choices in Western Australia and to highlight any gaps that might exist. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything that you might say outside today's proceedings. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet. The audiovisual recording will be available on the committee's website following the hearing.

Could you please both introduce yourselves for the record.

**Arch. COSTELLOE:** I will begin. My name is Tim Costelloe. I am the Catholic Archbishop of Perth.

**Rev. Dr PARKINSON:** My name is Joe Parkinson. I am a priest of Perth. I work for Tim Costelloe. I am the director of the LJ Goody Bioethics Centre in Mt Hawthorn.

[5.10 pm]

**The CHAIR:** Do either of you have any questions about your attendance today?

**The WITNESSES:** No.

**The CHAIR:** Before we begin with our questions, do you want to make an opening statement?

**Arch. COSTELLOE:** I certainly would like to.

**The CHAIR:** Please do.

**Arch. COSTELLOE:** I really wanted to make three points if I could, as a general introduction but, first of all, to thank you for the opportunity of addressing this group. Of course, I am speaking in my capacity as the Catholic Archbishop of Perth and also therefore the Metropolitan Archbishop of Western Australia. I will not repeat in detail everything I said in my submission but I did want to draw attention to what I would perhaps call the depth and the reach of the Catholic Church's engagement in what we might call, generally, outreach to people in need. I am speaking in the name of an institution which, while understandably and justifiably has been severely criticised for dreadful failures in the area of the sexual abuse of children and young people, nevertheless continues to be a major contributor to the wellbeing of our society—of everyone in our society, not just Catholics.

The statistics that are there in my submission indicate, I think, that the Catholic Church in Western Australia is deeply engaged with the social fabric of our society and is a major contributor to the wellbeing of many people in our society. We also, as the Catholic Church, represent a religious, a

moral and a social tradition that reaches back a long way—2 000 years. It is a long history of experience, reflection and accumulated wisdom on the human condition. I think it is important that this voice be heard and I am grateful for the chance that the voice can be heard. I want to say that I think fundamental to the tradition which I come from and from which I am speaking is the idea of an innate and equal dignity of every human person. That is not unique to us, of course; that is very widely held across many sectors of society, but it is characteristic of our tradition.

As I have indicated, our concern in coming this afternoon is not just to speak on behalf of Catholics—not at all. Our concern is to speak on behalf of what we would believe is the best interests of everybody in our society. They are really just three simple points; simple in one sense, but quite complex in another way. I think the first one—Dr Parkinson will probably elaborate on these as well—is that I wanted to draw the committee's attention to a very key distinction that is very, very clearly recognised, certainly in the Catholic tradition, between medically indicated treatments whose primary intention is to relieve pain, even if in administering pain relief, the person's life will be shortened, but that is not the intention of administering the medicine, but rather the intention is to relieve pain. That is a very different story to a deliberate action whose primary intention is to end a person's life. In the Catholic moral tradition, the former—that is, taking whatever measures are available to us to relieve pain even if it means shortening a person's life—is both a justified and even a recommended action in the Catholic tradition. I am only in a sense going on hearsay here, but it seems to me there is a fairly widespread agreement in the medical community that in most cases today, contemporary pain relief regimes can ensure that people do not die an agonising death. We are not really dealing here with two stark alternatives—either euthanasia or an agonising death. There is a third alternative and that third alternative is properly resourced, high quality multi-disciplinary palliative care. That third choice provides for the possibility of a dignified end to life supported by a whole variety of approaches which seek to address the physical, the psychological and the spiritual needs of people rather than just a simple step to end a person's life. I think also—just related to this again, it is not something I can prove with statistics, but it is a strong impression of mine—that many people do think that what we are dealing with here is this choice between either euthanasia or an agonising death. I think possibly much of the support or the reported support in favour of euthanasia could well be based on that misapprehension and I think it is vital that that be clarified for people.

The second point which I think is a tremendously important point is that one of the most fundamental and foundational principles upon which our society, at least until now, has been based is that it is never permissible to deliberately take the life of an innocent person. That is a fundamental and foundational principle, as I say, which until now has been almost universally accepted. Euthanasia and assisted suicide would both violate that fundamental principle and would introduce a new principle which states that there are in fact occasions when it is permissible and praiseworthy and possibly eventually even obligatory in certain cases to deliberately take the life of an innocent human person. I think that that is a step that a society should not take without an enormous amount of careful reflection, because this changes the whole understanding of the inviolability and dignity of human life. I have a lot of other points to make about that but perhaps they will come up in the questions.

The third key point is really the question of personal autonomy and the argument that everybody should have the right to make these decisions for themselves and that nobody has the right to interfere with these decisions. I think the question of personal autonomy is slightly different from the question of absolute personal autonomy, because I think we all exist as persons in society. We do not exist as completely isolated, autonomous people, whose decisions have no impact on anybody else. So I think our rights have to be balanced by our responsibilities to the society of which

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we are a part and to which we have certain obligations. We are not talking about a private and personal decision when we are talking about euthanasia or voluntary assisted dying; we are talking about a decision which, fundamentally, alters a foundational principle upon which our society has been built. So no matter how private the decision might be in one sense that a person might take to seek euthanasia or assisted dying, inevitably, because of the web of relationships that are part of being human, it has impacts beyond the person him or herself and their family. They would be the three key points I would like to address. Thank you.

**The CHAIR:** Thank you Archbishop. I will touch on palliative care. Reverend, did you want to provide an opening statement as well?

**Rev. Dr PARKINSON:** If I might, just briefly.

**The CHAIR:** Yes, please do.

**Rev. Dr PARKINSON:** Thank you, Chair.

Like the Archbishop, I thank you for the opportunity and for your diligence in canvassing a broad range of opinions on this because it is a disputed question. I note the terms of reference of the inquiry and the questions that you have indicated you would like to pursue and, in particular, your general interest in understanding a Christian perspective on the medical practice and laws relating to end-of-life choices, including assisted dying, assisted suicide and euthanasia. I think having an openness to hear that perspective is one of the strengths of the committee's inquiry.

I would initially get on the front foot: I note and I refute two of the claims that lie at the heart of the debate at the moment, and one is that there is overwhelming public support for euthanasia. I will happily debate that with you, looking at the data. The other is that the main reason we need euthanasia is to relieve intractable pain and on that I think the Archbishop has already commented. I understand that you have heard evidence around the principle of double effect. The Archbishop has referred to that. My recommendation in regard to term of reference 1 of the inquiry would be that you can provide legal protection to any doctor who acts according to clinical indications and the professional practice stands.

[5.20 pm]

That is to say, if the patient's condition is truly indicating a particular treatment and this is the standard that would apply—that other physicians would apply in a similar situation—then the doctor applying that treatment should be given the protection of law. That can be achieved by a simple amendment to the medical act. It doesn't need to go into the realm of health directives or enduring guardianship at all; it is a relatively easy insertion. Like the archbishop, I believe there is a lot of confusion around what palliative care is. I have family members who are engaged in providing palliative care in different parts of the state. What I see in nursing homes and in home delivered care is good, but it is not the standard of care I think Western Australians deserve. Too little palliative care is delivered by multidisciplinary teams that address all of the patient's needs: the physical, mental, psychological, social, relational, spiritual—all of those things at the same time. Too little palliative care is delivered well ahead of time; too often it is delayed until the last weeks or months of life. A recommendation was made through the National Health and Medical Research Council some years ago that palliative care should be enrolled as soon as a person is diagnosed with a terminal illness, even if the termination point is 10 years down the track. What that is about is enabling this person for the whole length of that journey to exercise choices about their care.

In the Rossiter decision—this is now with regard to term of reference 4—the Chief Justice acknowledged Christian Rossiter's right to refuse treatment, but he also required Mr Rossiter to receive advice from a palliative care specialist before he exercised that freedom. I assume that that

was so that Mr Rossiter's final decision would be fully informed. I infer from that that anyone who is making an end-of-life decision without advice from a specialist palliative care physician is not acting with full information and, as an ethicist, I would suggest that their medical decision could be challenged on the grounds of validity.

In the Catholic medical tradition, we prioritise respect for the dignity and rights of a patient and for personal choices. The only limitation is that we ask that our right for self-respect for our integrity also be respected. We do not seek to keep people alive at all costs, but neither will we actively intentionally kill a person. We believe that that is fundamentally a contradiction to our commitment to the dignity of every person.

The committee, I presume, wishes to expand and not contract patient choices, and so I would call upon you to recommend to government a major overhaul, firstly, in the model of palliative care that is available to all Western Australians. I think the models that we have available—there are at least three—by and large, are not adequate. An adequate model of palliative care needs to include that multidisciplinary resource, and so your recommendations would need to include issues around equal access; appropriate staffing, which includes the training of physicians and specialist nurses, nurse specialists; and, in terms of health economics and allocation of resources, whether the best model of palliative care would be one delivered by the state or one delivered by non-government organisations.

I might use the phrase “on time, on budget”. I think that the private health system has a reputation for delivering projects on time, on budget and with excellent service. The Catholic health and aged-care system, as well as our disability services, are ready and willing to partner with government to grow services in all of these areas. We are ready if you are your willing. For the reasons described in my submission, I would ask that you do not recommend any form of assisted dying.

**The CHAIR:** In relation to palliative care—this is a question for either or both of you—we have heard from palliative care specialists, of which there are, as you have rightly said, only a handful in Western Australia. I think it is reasonable to say that none of them have said that palliative care is 100 per cent effective all of the time; that we have made huge advances in the ability to manage pain and suffering at the end of life. But there are the cases where there is intractable pain at the end of life. Given that your submission outlines that palliative care is the answer, what is the answer for those people who are experiencing incredible pain at the end of their lives?

**Rev. Dr PARKINSON:** I shall have a go at that one. If a patient wishes to have freedom from pain and full consciousness, that is probably a stretch too far for any medical system, even in ideal circumstances.

**The CHAIR:** Which is a current legal practice?

**Rev. Dr PARKINSON:** If you are able to provide consciousness, if you are able to preserve consciousness with pain relief, that is great. But you will also have heard, I am sure, reference to palliative sedation—so dealing with if not the pain, then the agitation that can accompany pain at the end, that can be managed; patients can be given relief from that. It is not, as we have discussed, about killing a patient, it is about controlling pain. The beauty of palliative sedation is that it is temporary, so it is reversible. A patient can be given a break, get relief, have a couple of days good solid sleep and then be brought out of that and be able to continue making their autonomous health care choices. I think there might be a bit of a myth floating around that somehow medicine ought to be able to provide everything that I want. The fact is, it never has been able and probably never will be able to provide both full consciousness and complete freedom from pain.

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**Hon ROBIN CHAPPLE:** On that, we have had a lot of different people present to us—palliative care specialists—but one of the things that was brought up literally the other day was from a frontline palliative care service provider; that was, that even though they had induced a level of unconsciousness or sedation, the patient was clearly, through grimacing, through movement, whatever else, still even though unconscious and sedated, experiencing pain. Where do we go with that situation?

**Rev. Dr PARKINSON:** I do not have specific medical knowledge around that. I would be surprised if it was not possible to provide medication so that at least the patient would not remember that pain. I am thinking about something like propofol. Again, I really do believe that medicine does have its limits, and we cannot overstate that. I think people's expectations also have to be contained. I think it is quite possible for people to expect far too much from medicine. Do we really expect that I will have an easy end? Is that really what I can ask of not only of my doctor but of the state? Can I make that demand of you? I wonder if that is not an unrealistic expectation.

**Mr J.E. McGRATH:** Further to that question, you would understand that what we are being told is that there are people in that stage of their dying who say to the GP or to the specialist, "I don't want to go on anymore. Just end it for me."

**Rev. Dr PARKINSON:** Yes, I understand that.

**Mr J.E. McGRATH:** Some of these people might be people who have faith too.

**Rev. Dr PARKINSON:** Absolutely.

**Mr J.E. McGRATH:** Do you understand that this could still be happening out there and putting doctors in difficult positions?

[5.30 pm]

**Rev. Dr PARKINSON:** I absolutely know it is happening out there. I am hearing from palliative care specialists in other parts of Australia who are telling me exactly that. As an indication, a specialist out of Melbourne working at Cabrini says that she usually hears three things. One is, "I want to die." When she hears that, she thinks, "What is it about your condition that's causing you distress such that you would rather be dead?" That begins a conversation. Very often it is not physical pain; it may be other kinds of discomfort or suffering or whatever. If we address those issues, very often that anxiety about dying fades down. The second she says are people who say, "I've had enough." They're usually people who have had a series of treatments that may have worked in the beginning, are not working now so, "Whatever treatment you are offering me, it's not helping." There you are facing the question of, "Let's stop that treatment and work at comfort care. Put all our energy not into cure but into purely providing comfort as best we can through to the end." In this doctor's experience, that was a relatively small number of people. The third she said was the smallest number of people, who said, "Euthanase me. Put me out of my misery." In her view, that group of people belonged with the first. What is it about your experience that says to you I'd rather be dead? If we know what those things are, maybe we can address them.

Now, none of that belies what you are hearing from the doctors. I have no difficulty at all with the fact that some people would prefer to be put down. I absolutely understand that. My difficulty with saying, "Let's arrange our legal system to make that possible", is that first of all I do not believe it is possible to arrange a legal system in which you can contain that breach of the prohibition on one person killing another to just this group of people. As I said in my submission, you will inevitably run into claims of discrimination: why can this person access that service and not me? The pressure will be on, not on your Parliament but on the next one or the one after that, to expand that. The only way you can avoid that bracket creep is not to cross the bridge in the first place. In other words, I

understand the desire some people have to die. I have watched both of my parents die. My father in particular was quite distressing. But none of that convinces me that it is a wise thing to change our system of law. I do not believe it can be done safely and securely. I think we have to find other ways to meet the needs of the people you are talking about. It may take longer, it may take more money but I think that it is the better way if we are truly about being a society that respects people's dignity.

**The CHAIR:** In your opening statement you touched on the public support around voluntary assisted dying. We have certainly had a lot of evidence and submissions to this inquiry from people, particularly older people, who feel very strongly about the right to choose their ending, particularly if they have a chronic or terminal illness. That is pretty strong evidence to us as legislators. What is your response to that?

**Rev. Dr PARKINSON:** I cannot comment on individuals whom you have spoken to, but the public rhetoric tells us it is around 83, 85, up to 89 per cent support. I note that the source for that data is an SMS poll conducted by Roy Morgan just a few months ago in Victoria. The SMS poll asked two questions, which were the same two questions that Roy Morgan asked originally in 1946. I can read you the questions if you like. In fact, I will. May I?

**The CHAIR:** Sure.

**Rev. Dr PARKINSON:** "For hopelessly ill people are experiencing unrelievable suffering, if there is absolutely no chance of a patient recovering should the doctor let the patient die or should the doctor try to keep the patient alive as long as possible?" Well, of course we are going to say no. We are going to say, "Let the patient die", obviously. The second question was: "If a hopelessly ill patient with no chance of recovering asks for a lethal dose, should a doctor be allowed to give a lethal dose or not? Again, hopelessly ill, no chance of recovery, lethal dose. That is the only option on offer. We come back to the situation that the archbishop has described: it is either in pain or euthanasia. Who is not going to vote for euthanasia? I repeat: they are questions that Roy Morgan have asked now for over 50 years. They ask the same two questions so that their results are comparable across time; I do not have a problem with that. But the fact is that the terrain has changed.

Put that aside. The British attempt to introduce euthanasia some years ago—the Falconer inquiry and recommendations from that—initially turned up support for euthanasia at around 80 per cent, 75 per cent, but it was on the back of similar polls that offered a binary option. As soon as people were given more information, the level of support started to peel away and so there were questions put around the risk of people feeling that they would become a burden on their friends or a steady increase in the reach of palliative care; what if that were to be a risk. Then there was the cost issue—£3 000 or £4 000 a week to provide inpatient hospice care as against the £5 treatment for euthanasia. Once you start adding in a bit more information, people begin to think a bit more about the issues and shift. Support for the Falconer proposal dropped from 80 per cent to 43 per cent, and ended up with 43 per cent for, 43 per cent against and 14 per cent undecided, so that does not solve your problem. But I just want to indicate that the data we are hearing about in the public arena is utterly unreliable. I have been reading research proposals for 30 years. For all of the —

**The CHAIR:** With respect, reverend, my question was about the submissions we have had to this inquiry, not SMS polls about individuals.

**Rev. Dr PARKINSON:** I cannot comment on individuals but I can comment on the direction of the public debate around this, and the public debate is misinformed.

**Hon NICK GOIRAN:** Further to this, Reverend Parkinson, you might be interested to know that of the 650 submissions that the committee has received, a majority of the submissions are opposed to

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the notion of physician-assisted suicide. So I found your unpacking of the poll results quite enlightening and perhaps a useful explanation as to why it is the case that every time this debate comes up in various Parliaments around the world, the numbers in the Parliaments are very tight and nowhere near the 80 and 90 per cent because obviously the parliamentarians have to wrestle with actual questions, not the loaded questions. In your response you indicated that the terrain has changed. Can you just explain what you mean by the terrain having changed?

**Rev. Dr PARKINSON:** Purely that what was possible to achieve with medicine in 1946, we have gone a long way past that now.

**The CHAIR:** You made some comments around double effect, which is the Catholic doctrine. Do you think the law adequately protects medical practitioners relying on the doctrine of double effect?

[5.40 pm]

**Rev. Dr PARKINSON:** I think I refer to that earlier on. I think it does and I think that the way that the law is applied, because there have been one or two occasions—one that I am particularly conscious of in the hospice at Murdoch some years ago where a doctor was investigated for practices. I think that the law actually does rely on it to some extent, although it is not a legal principle. It is an ethical principle. I did say in my opening comments that if we have any lingering doubts about the protection afforded to physicians, it can be rectified with a simple amendment to the medical act. I do not see that as a major issue, except that I do not know that our medical schools understand the doctrine very well and I do not know that a lot of doctors understand it very well.

**The CHAIR:** What amendment would you make?

**Rev. Dr PARKINSON:** We would make an insertion that a doctor who delivers a treatment which is clinically indicated and complies with professional practice standards will be understood to have acted within the law. It is sufficiently flexible to allow the profession to continue to set the parameters. I think if you try to regulate the royal colleges, you might run into strife, but I think you can create a statute that allows the royal colleges to determine what is best practice and also to enshrine that in the statute.

**Mr S.A. MILLMAN:** Does that not defer the decision-making away from—I accept that it is an ethical question, but it is also a legal question. As legislators we have a duty to discharge an obligation in terms of formulating laws. Does that not shift the difficult assessment that we have to do away from our obligation as legislators onto medical practitioners and say, “This is all too hard. Why don’t you deal with it as medical practitioners?”

**Rev. Dr PARKINSON:** Can I give you another example?

**Mr S.A. MILLMAN:** Yes. You understand where I am coming from?

**Rev. Dr PARKINSON:** I understand the question exactly. With absolute respect for the work that you people undertake, and it is not one that I would want to undertake, you simply cannot legislate everything. It is not possible. What constitutes safe clinical practice today will be outdated in six months or 12 months or two years’ time. The process of trying to govern these practices by statute—statute law is a blunt instrument. It is not capable of dealing with either the rapid pace of change in technology or the results of research that are continually ongoing. I think you need to find ways that preserve your duty as legislators to control the environment, as it were, but I do not believe it is possible in statute law. I do not think it is nimble enough to deal with the sort of changes that would inevitably have to be made. I could quote other examples in other areas of law but it is outside the realm of this inquiry. Does that answer your question?

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**Mr S.A. MILLMAN:** I understand where you are coming from. I think that just because the exercise is difficult, does not mean we should avoid it. I think if we are going to be good legislators that we need to tackle difficult issues.

**Rev. Dr PARKINSON:** I absolutely agree.

**Mr S.A. MILLMAN:** Perhaps I repose more faith in the law and in Parliament, but I think laws can respond appropriately to community concerns. Given that this is a legal question, I just worry about whether or not we are discharging our obligation by, essentially, saying the royal colleges are the ones who are in the best position to —

**The CHAIR:** There are two parts to that. There is discharging your obligation and giving doctors an enormous amount of power, which I think has been rejected by the High Court.

**Rev. Dr PARKINSON:** I would suggest that another way of framing it would be that I think it is entirely within your legislative responsibility to trust the medical professions.

**Hon ROBIN CHAPPLE:** I noticed in your submission you said statutory advance care planning instruments are helpful but not perfect. None can guarantee that a person's personal preferences would be followed. Could you expand on that? Also, this is about—assuming that statement is correct—a person's personal preference.

**Rev. Dr PARKINSON:** Absolutely. That is a particularly good question. I do not have the act in front of me so I cannot quote you the section numbers, but in regard to advance health directives, it is clear in the act that an advance health directive, in order to be applicable in a given situation, must be made with reference to the particular condition for which the patient has been hospitalised. It has to be specified in an advance health directive. An issue arises: is this hospitalisation for that reason or is there some other reason? There is a question around whether the advance health directive remains active, because there is provision to renew advance health directives—I think it is on a two-yearly basis.

**Hon ROBIN CHAPPLE:** Or even just announce that you do not want to —

**Rev. Dr PARKINSON:** Or even just to say, “I have changed my mind”—absolutely. I note that if you were taken into an accident and emergency department and the treating physicians felt that your life was at risk, they are authorised to take whatever means that they wish to save your life, even if the reason for admission is attempted suicide and even if you have an advance health directive that says you do not want to be resuscitated. The law protects the clinicians who provide care for you as they would for anyone else. With all due respect to you as legislators—I do not know whether any of you were in your houses when that act was passed—you can drive a truck through the provision. I believe the only way to make a watertight advance health directive is to have a really good team of lawyers with you. It is constructed in such a way to provide some guarantee to the patient but to preserve the professional autonomy of the healthcare providers. It is a really difficult balancing act.

**Hon ROBIN CHAPPLE:** We have heard that as well. One of the things we have heard from people who wanted to fill it in is that it is far too complex.

**Rev. Dr PARKINSON:** Absolutely.

**Hon ROBIN CHAPPLE:** They want a very simple “I do not want to survive” sort of thing. Moving on from that, this really comes down to a person's general preference will be followed. If the person says, “If I end up with a particular condition or disease which would lead to a terminal outcome, I refuse medication or sustenance or whatever.” Where do you sit with that refusal?

**Rev. Dr PARKINSON:** I am very comfortable with it.

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**Hon ROBIN CHAPPLE:** So that is fine. Taking it to the next stage, associated with personal autonomy again, if a law was to be passed that said that you as an individual could be provided with sodium pentothal or whatever to end your life but the doctor or medical professionals were not going to be involved in that process, when you sit with that?

**Rev. Dr PARKINSON:** I think there are two parts to my answer to that. One is that there is a big difference between a capacity to refuse a treatment and the capacity to demand a treatment. None of the instruments that we have allow a patient to demand a treatment. Secondly, the only way that we could arrange that kind of scenario is if that particular treatment—sodium pentothal—is legislated. You actually make an exception that this is a treatment which can be offered. Here, again, I think you might have a bit of difficulty with the medical professions because they will want to be clear that this is actually a clinically indicated treatment and that it is according to their professional practice standards. I think that a doctor who acted outside those two parameters is sailing very close to the wind. There is a second issue around that. The nub of your question, though, is how would I respond to a situation in which a patient asks for this and the doctor says, “Well, I do not want to provide it.” I think we have to, as much as I respect Parliament’s right and, perhaps duty to create opportunities for people, Parliament also has an obligation, I believe, to respect the conscience of people who do not wish to.

I would suggest then that the only way I could feel comfortable with that would be with the blanket right of conscientious objection, not only from individuals but from institutions as well; that is, institutions, who we can treat as legal persons, would have the same right as an actual person.

**Hon ROBIN CHAPPLE:** Currently I understand that your hospitals do not carry out certain procedures.

**Rev. Dr PARKINSON:** Yes.

**Hon ROBIN CHAPPLE:** And we understand that, so that has to be respected.

**Rev. Dr PARKINSON:** What I would hate to see is legislation that offers people options that they do not have to take if other options have been made available. So, rather than simply saying we are going to allow this as a solution, I would much rather Parliament said, “Let’s do all that we can to optimise everyone’s choices, invest in that, invest in the training, invest in the provision of services and equal access for everyone.” I think if we are really interested in expanding rather than confining people’s choices, that would be a better way to do it.

**The CHAIR:** Can I put a question to you along similar lines that I put to a previous witness today who had similar views that my colleague has outlined: those who have an objection to providing treatment should be protected by the law. Do you think the same principle applies to those who want to be protected from religious views and who would like the treatments available to them?

**Rev. Dr PARKINSON:** I am sorry, I do not understand the question.

**The CHAIR:** So those people who do require or would like broader treatments, that legislators have a responsibility to protect them from religious views in terms of medical treatment as well?

**Rev. Dr PARKINSON:** Again, I am not sure that I understand. Is there an implication that religious views might be imposed on people who do not hold them?

**The CHAIR:** Yes.

**Rev. Dr PARKINSON:** I do not know that that is part of our tradition. I am not aware of that being part of our tradition. Certainly as someone who has been closely associated with Catholic Healthcare nationally now over the last 20 years or so, I am not aware of anyone who has had religious views forced upon them.

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**The CHAIR:** Can you tell us whether Catholic Healthcare provides all legal medical services currently where they receive public funding?

**Rev. Dr PARKINSON:** All services that the state purchases are provided, yes.

**The CHAIR:** That was not quite my question.

**Rev. Dr PARKINSON:** Well, that is the answer.

**The CHAIR:** My question was: do you provide all services that are legally available?

**Rev. Dr PARKINSON:** We are not able to. We can only provide services that the state purchases.

**The CHAIR:** Do you have restricted services that you will not provide?

**Rev. Dr PARKINSON:** We have services that the state has agreed it will not purchase.

**The CHAIR:** And what are they?

**Rev. Dr PARKINSON:** Termination of pregnancy, surgical sterilisation and some procedures around in-vitro fertilisation. They would be the three areas, but again the state decided it would not purchase them and so we have no obligation to provide them.

**The CHAIR:** We had evidence from St John of God that they outlined that in those negotiations that they were St John of God's restricted services.

**Mr R.R. WHITBY:** If the state requested to purchase them, what would your response be?

**Rev. Dr PARKINSON:** You would need to find another supplier. With respect, Madam Chair, the way that that unfolded was that the government at the time offered the opportunity to say, "Yes, we will; no, we won't", and the government said, "Yes, we can live with that."

**The CHAIR:** Yes, I am aware of that.

**Rev. Dr PARKINSON:** I think unfortunately sometimes in the press it plays out as though St John of God refuses to provide treatments. Actually, it is not lawfully permitted to provide those treatments because the state has not licensed us to provide them. It has not purchased them.

**Mr R.R. WHITBY:** Reverend, you said that your preferred option in this debate would be increasing the quality and breadth of palliative care.

**Rev. Dr PARKINSON:** Yes.

**Mr R.R. WHITBY:** And I agree with you; that would be a wonderful option. But we are told also that we have one of the best palliative care systems in the world already, and we still have this issue. We still hear evidence from people who have gone through the palliative care system with loved ones, who have had real experience at the very end of life and who tell us that their loved ones make impassioned pleas for the ability to have their life ended with assistance. We are sitting around this table in a comfortable position. We have never confronted that scenario personally. I guess it is very hard to tell how we might act individually too; what you, the archbishop or myself may actually want at that very end of life.

**Rev. Dr PARKINSON:** That is very true.

**Mr R.R. WHITBY:** Given that, why can we as a humane society deny that choice to individuals?

**Rev. Dr PARKINSON:** I am just trying to get back to one of your earlier statements, which is the place I wanted to start. The fact that we have an excellent palliative care system and we still have the problem is probably a commentary on palliative care systems elsewhere, but it is also a statement of fact that we do not have a system; we actually have several. There are several modes of delivery; there are several modes of understanding palliative care. For example, home-based palliative care

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is different from palliative care delivered in an acute medical ward, which is different from palliative care delivered in a specialised hospice setting. There are different resources available, there is different expertise available, there is different investment of resources and so on. So the fact that many people have very unfortunate and terrifying experiences of loved ones dying, even though they are receiving palliative care—I am not sure we can just draw a straight line and connect all of those together. My option would be the first two are fine, but let us really build up the third one where we are able actually to throw everything at people and build up people's expectation that that is their right to have access to that quality of stuff. I have suffered a near-death experience, but I have never been in a palliative care position. As a minister of religion called to people who are dying I have seen that many times, both in government and in private hospitals. There are no easy ways to talk about it; there are no easy answers to give. You get to a point at which the best thing you can do is accompany a person often in silence, but just offering the gift of one's presence so that on the journey they are travelling they are at least not travelling alone. I do not know that I can answer your question any better than that.

**The CHAIR:** Reverend, we are getting close to time. I have one more question. If someone in a Catholic Healthcare institution chose to withdraw from medical treatment, would they be supported in that decision?

**Rev. Dr PARKINSON:** Yes.

**The CHAIR:** Even if the doctor felt that the treatment was not futile?

**Rev. Dr PARKINSON:** Yes, there is no question. There is an ethical question there, which in our system of thinking is that it is a perfectly defensible decision for someone to make. If the patient determines that the treatment is either not therapeutically beneficial or unreasonably burdensome, we will follow their decision. That is quite apart from the legal right they have to refuse treatment, which was emphasised in the Rossiter decision. So, the answer to both questions is unequivocally and without hesitation yes.

**The CHAIR:** Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. If you wish to provide clarifying information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript of evidence. Thank you both very much for your time today and for coming to speak to us. It is much appreciated.

**Hearing concluded at 6.00 pm**

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