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
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SESSION THREE

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 1.30 pm

Mr LAURENCE VAN der PLAS
Research Officer, Association for Reformed Political Action, examined:

Mr ROBERT VAN der LINDE
Chairman, Association for Reformed Political Action, examined:

The CHAIR: Welcome this afternoon. Thank you for joining us and giving your time to give evidence for our inquiry. 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 and I am the Chair of the joint select committee. We have Mr Simon Millman; Hon Sally Talbot; Mr John McGrath; Dr Jeannine Purdy, our principal research officer; Hon Colin Holt; Hon Nick Goiran; 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 you might say outside of 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 also be available on the committee's website following the hearing. Do any of you have any questions about your attendance today?

The WITNESSES: No.

The CHAIR: Before we move to questions, do either of you want to make an opening statement?

Mr VAN der PLAS: Yes, please.

The CHAIR: Please do.

Mr VAN der PLAS: Thank you. Good afternoon, committee members. Thank you for the opportunity to give evidence to this inquiry. My name is Laurence Van der Plas, as mentioned, and I am the research officer for the Association for Reformed Political Action, which is also known as ARPA. With me today, as previously introduced, is Rob Van der Linde, who is our chairman. Your research officer advised us that we could give an opening statement prior to answering your questions. In this opening address I would like to do three things, if I may. Firstly, explain ARPA, which is the organisation that we are representing today; then also paint a picture for you about the Reformed Christian perspective of human life, death and suffering; and then, lastly, interact very briefly with the terms of reference, although that was already largely covered by our submission and I will not repeat or re-read all of that.

From the outset I do want to acknowledge that this is an incredibly complex area to investigate, and that your committee has a very challenging task. We appreciate the wide variety of perspectives that you are open to receiving. The recommendations made by this inquiry have the potential to shape laws which will have a profound impact on WA citizens for decades to come. Issues involved in end-of-life care are very sensitive and often deeply personal, especially when it concerns serious and terminal illnesses. We are often talking here about situations, as I am sure you know, that involve people we deeply love. That is actually the case for both Rob and myself here as well. Both of Rob's parents have battled cancer in the last two years, and for myself I watched a grandfather, an aunt and an uncle succumb to cancer, which claimed their lives, and I have also seen many family

members take preventive action in order not to have cancer, so to speak. Our family has a genetic predisposition to contracting cancer.

Rob and I appear before you today on behalf of ARPA, the Association for Reformed Political Action. The "Reformed" is a link to the Free Reformed Churches of Australia, the denomination from which our members are drawn. There are 14 Free Reformed congregations in WA, with about 4 300 members. Free Reformed Churches are a Protestant denomination. They trace their roots back to the Protestant reformation in the sixteenth century. ARPA itself is a grassroots and member-run organisation, which is the way that Reformed community organisations usually operate. So we are not here on behalf of a synod or anything like that. ARPA was established in 2009. Our aim really is to provide a two-way link between our members and politicians. On the one hand we encourage our members to be politically aware, to understand what is going on and to be involved; on the other hand we try to represent the Reformed community to you, which is what we are doing today, hopefully.

ARPA has taken the matter of euthanasia and assisted suicide in particular quite seriously, ever since reports emerged in May last year that Hon Robin Chapple, MLC, was willing to discuss drafting a euthanasia bill, and also when the health minister, Hon Roger Cook, gave public support for terminally ill patients to have the ability to end their lives. We concluded a thorough report into euthanasia and assisted suicide last July, and we used that report to form the basis for our submission to your inquiry in October last year.

As Reformed Christians we do not wish to impose our religion; nor have we forgotten the notion of separation between church and state. Institutionally, that separation is very good and we would say it is even necessary. However, we do believe that faith plays an important role—in fact, an essential role—in answering moral and ethical questions like the ones we are dealing with today; questions such as what is life, what is death and what does it mean to be human. We believe that we know God through the world that he has made and that his will is revealed to us through the Bible, which we believe is his inspired word. It is not my intention to preach to you this afternoon. I say these things purely to paint an accurate picture of where we as Reformed Christians are coming from in this area, and also to explain what guides our thinking, specifically on the question of whether as part of a person's end-of-life journey our state should legalise acts which have as their primary aim the extinction of human life.

In that regard, I would like to draw your attention to the following. Firstly, Christians believe that human life has sanctity, which we believe means it is sacred or set apart. Human life is distinct from other life, such as animal life, because humans were created by God in his image and given an eternal soul. Secondly, God gave humans specific laws, many of which form the basis for the laws that we still uphold today. One of these, the sixth commandment, includes a prohibition on murder. Thirdly, Christians do not believe that death is an end but rather that it is an entrance to eternal life, a life either in God's presence or not. For us, death is not a full stop, but a comma—it is a transition. Fourthly, because we believe death brings us into God's presence, we believe its time is not for us to choose. The Bible speaks in a number of places about God being the one who numbers our days. This does not mean that we do not sometimes desire death or relief from suffering. We read about that in the Bible as well. It also does not mean that we believe that futile treatment cannot be refused. Fifth and lastly, we believe that there really is no such thing as a good death. We believe that death entered the world because of sin; that death is an enemy. Euthanasia or assisted suicide will not give us control over death; it will give into it.

We believe that our concerns are relevant under terms of reference (a) and (b) of your inquiry. I will not repeat the contents of our submission, but, briefly, our submission highlights two concerns

under term of reference (a), specifically with reference to the exercising of preferences. Our first concern is that people's knowledge about effective palliative care plays a crucial role in reducing the demand, possibly, for euthanasia. Secondly, we are concerned that the elderly are vulnerable when it comes to exercising their preferences. Under term of reference (b), we would like to draw your attention to jurisdictions where legislation has already allowed for euthanasia or assisted suicide. Our submission draws attention to nine matters, which, briefly listed, are, firstly, why are people accessing euthanasia? There are statistics which challenge the narrative that euthanasia is primarily sought for unbearable pain. Secondly, do safeguards work? There is evidence from Canada—a jurisdiction where euthanasia is fairly conservative and was only recently introduced—showing that safeguards can fail, and that when they do there is very limited follow-up.

[1.40 pm]

Thirdly, is euthanasia simple? We are not medical experts. We are sure that you have heard from witnesses who are far more qualified in this area than us. We have read that euthanasia does not guarantee a pain-free death or even, in all cases, a dignified one.

Fourthly, are doctors willing to participate and what effect does it have on them? We have found that in one province in Canada, in Ontario, doctors are withdrawing as providers.

Fifthly, will euthanasia lower suicide rates? We are aware that the coroner has spoken to you, and in Victoria we heard this also came up quite frequently. There are statistics from the United States in particular which will challenge the narrative that euthanasia will lower suicide rates, even in the age bracket above 65.

Sixthly, can euthanasia be contained? There are examples from a number of jurisdictions which show that euthanasia could be compared to Pandora's box and that once you open it, a process of expansion follows.

Seventhly, are there flow-on effects? There are other ethical dilemmas we have read that would need to be solved if euthanasia is legalised, including particularly matters relating to organ donation and receipt of those organs.

Eighthly, what about conscientious objectors? Once something is legalised, we feel it can soon become a right. When things are a right, there is often an obligation to provide as well.

Lastly, the availability of euthanasia can, and has overseas, also act as a disincentive for other medical treatments, especially if these treatments are costly.

Our submission made a total of eight recommendations to your committee. Again, very briefly listed: firstly, we would ask you to reject euthanasia or assisted suicide as an end-of-life choice for our state. Secondly, we would call for an acknowledgement that a significant proportion of the WA population does object to euthanasia or assisted suicide for reasons which are fundamentally linked to their Christian faith and their beliefs about the meaning of human life. Their objection would also preclude them from any form of participation in it. Thirdly, we would ask for greater funding for, and access to, palliative care so that any fears people have associated with dying can be spoken to and alleviated. Fourthly, acknowledgement of the issue of elder abuse and its potential to contribute to detrimental end-of-life choices. Fifthly, a rigorous examination of the pro-euthanasia and assisted suicide arguments, especially the arguments that the primary use is to alleviate pain. Sixthly, reporting to the Parliament that safeguards cannot completely protect people from wrongful deaths, even in jurisdictions where control is tight. Seventhly, a risk assessment of the best and worst outcomes in both scenarios—I am happy to speak to that further, should you wish—basically saying, under legalised assisted dying or not, what is the best possible outcome in both cases and what is the worst possible outcome in both cases? Finally, an acknowledgement that allowing

euthanasia in any form will open a Pandora's box of other ethical dilemmas which our state will be called upon to solve.

To conclude this opening address, we are as a state with this inquiry partly answering this question: how do we respond to and help people who are desperate and suffering to the point that they want to end it all? Do we throw more effort into funding and promoting palliative care or do we as a state discard another part of our Judaeo–Christian legacy—facilitate suicide and walk down the road of starting, even in a very small way, to judge which lives are worthy of being ended, and approving death as a response to suffering? For reformed Christians who we represent, our faith prevents us from crossing that line. We truly believe that it is in the best interests of our fellow Western Australians not to cross it either. Thank you.

The CHAIR: You touched on lots of issues in your statement. You touched on futility of medical treatment. What is your organisation's position on futility of medical treatment?

Mr VAN der PLAS: In the sense of if treatment will have no further —

The CHAIR: Yes. If a doctor deems treatment to be absolutely futile and will not really contribute to the lengthening of a person's life; yes.

Mr VAN der PLAS: As an organisation, we will not have a position on it. I do not think as a church we would have a position on it either. Where we should draw the line, if you like, is, "Do we now go into an act which has as its primary aim the end of life?" We believe there is no biblical support for us that you must continue life at all costs. That would be a person's choice and that would be a very difficult choice to make. But overall, it is difficult for us to comment on that because we are not medical people either. But this idea that we now cross a line where we give something which will not relieve pain but this will end your life, that is where we definitely have difficulty.

The CHAIR: Does that apply to the circumstance where an individual is at the terminal phase of their illness and they choose to stop eating and drinking —

Mr VAN der PLAS: It is interesting you say that. I was talking to a nurse about this —

The CHAIR: — in order to bring that end nearer because they are obviously in a lot of pain, and suffering?

Mr VAN der PLAS: Yes. I do not know, Rob, whether you want to jump in at any point. I would be saying that in a sense I would see it as the same as us here saying, "I'm not going to eat or drink." Would I like you to make that decision? No, I would prefer you to keep eating and drinking. Can I stop you? No. But again, it comes into this realm of I would say that is an unfortunate situation and I would do everything I could to prevent it, but I would still say that is a different circumstance than now saying, "Okay, you wish to end it and we're happy to hasten that for you by giving you something."

Mr VAN der LINDE: I think that is an active decision by the individual in that circumstance and it is very, very hard for us to comment on those individual circumstances. Our focus is more on any active measures taken, particularly by third parties, where the object is to end life.

The CHAIR: On that, we have heard some evidence that doctors rely on their doctrine of double effect when administering sedation and opioids at the very end of life. Does the church have a position on that?

Mr VAN der LINDE: The church would have the position that the ultimate aim of giving any medication is primarily to ease the suffering and if a secondary effect of that is to hasten the death of the person, that is up to each individual case to be looked at. It is very difficult to make a blanket pronunciation on that.

Hon ROBIN CHAPPLE: Just touching on that, if I may. Obviously we have been hearing a lot of evidence from a wide range of people. It has been very informative to the committee. One of the issues that has been brought to our attention is that quite often what we call a medically induced coma, or that sort of sedation, does not relieve pain and that even people who are completely sedated show signs of anxiety, restlessness or stiffness of limbs due to pain. Obviously the sedation, which is pain management, is not achieving the result and at that stage the only option is to increase the dose to a point where the person dies. Can you contemplate that and give me a bit of an idea of what your views would be around that?

Mr VAN der LINDE: Once again I think that we are bordering on the edge of what we are qualified to say as an organisation in those sorts of scenarios. I think that is a very, very difficult decision to make and that needs to be obviously made by professional doctors in consultation with the patient et cetera. I think the salient point is where medication is administered, as long as everything is done with the technology that we have today and the developments that we have made to date with palliative care, as long as the intention is to ease suffering in the process of preserving the life of the patient.

Hon ROBIN CHAPPLE: I take you to the next point, if I may. There is at various stages over the last few years a different interpretation and direction around "do not resuscitate". Where do you sit with that being put on a person's chart—that if they have a cardiac arrest or they stop breathing for some reason, there is no attempt to revive?

[1.50 pm]

Mr VAN der PLAS: I actually know of Christians who do have such an order; in fact, some of them are in the medical field themselves. They have seen the effects of resuscitation, which can do a lot of good, but they have also seen—I say this not to preach but more to say that we believe that God numbers our days. He has them mapped out for us and for us we are trying to say, "What is the Lord's purpose here; what is happening to my body?" If I am 95 years of age and I have pneumonia and something happens and there is a "do not resuscitate"—again, this is the whole complexity of the issue. I understand that. Again, what is our aim here? If a "do not resuscitate" order is still a lot different than "I'm going to give you something" or "I'm going to do something which will end your life." That is the threshold for us. We are not saying life has to be prolonged at all cost. I was talking to a nurse this weekend and, yes, when someone is brain dead, for instance. Those things are very difficult and we do not mean to simplify that whatsoever, but do we go down the path of, "Now we will end it"? No; that we cannot conscience.

Hon ROBIN CHAPPLE: Obviously, you would say that your faith and your broad congregation in that faith, covering many different groups, would not be supportive or utilisers of end-of-life choices legislation which permitted either voluntary taking of medication or doctor-assisted medication. You would absolve yourselves from that and you would want to see that if legislation was brought forward your rights and your philosophy and your desires were respected within that legislation? Obviously, there are many different sorts of religious views, cultural views—all sorts of things—that flow in and around this issue. Clearly, we have to protect those people who are not of the same view, whether it be doctors, nurses, patients, whatever. Can you give me your thoughts around that and how you would like to see that resolved?

Mr VAN der PLAS: The obvious answer to that would be in the affirmative with one qualifying statement, which is that we would be very reluctant to see this discussion go down a path of, assuming this is legalised, "What would you like?" I do not believe that we are at that stage yet. We do feel there is a danger in starting to have the public discourse already going in that direction: If this all unfolds, what would your community want? I think it skews the argument a little bit. The

only other thing I would add is that I do not believe that this is all just about us. As I mentioned in my opening address, our family has a genetic predisposition to cancer. When I look into the future with this stuff, I sometimes think: what is going to happen to me when I am 60, 70 or 80? It is easy to say this now, I know, but I am willing to suffer a painful death if that ends up happening so that we do not go down this path where others who may not need to die may inadvertently end up dying. I also very respectfully question the narrative of—how do I put this? I would be wary of going down the path where the suffering at the end becomes the sole determining measure of what we do. Does that kind of make sense? I am willing to suffer; I am willing—to take one for the team—if that is what it takes at the end, okay, my last days, weeks or hours are awful, I am going to go before God's throne anyway. That will not change; that will remain the same. But what are the consequences for others as a result of that? It is not very well worded, I apologise. We do not do this thing every day—we are trying to put forward something.

Hon ROBIN CHAPPLE: You are doing fine.

Mr J.E. McGRATH: As MPs, we talk to a lot of people in our communities and often I know I raise this subject and I am sure our other members do, not only members on this committee but members of Parliament in Western Australia, because it is a big issue now facing us and facing our committee. A lot of the people we talk to say, "Yes, I think we should have a choice when it comes to that time, as an individual", but a lot of them also say, "Provided proper safeguards are put in place." You said earlier that safeguards can fail. What type of evidence have you got that you can talk to us about where if this legislation went through and we put in certain safeguards they might not meet the needs of fulfilling the aims of the legislation?

Mr VAN der PLAS: If I can, I am just going to find a section in a report which had some statistics from Canada. The trick is to also compare like with like, so we thought let us look at a jurisdiction which is similar in culture and similar in background to Australia, which would be Canada which also went down this path I think in October 2016.

Hon ROBIN CHAPPLE: I think it is the second dot point under (b).

Research Officer: Page 3.

Mr VAN der PLAS: Thank you. We found that in Quebec a review was done where of 262 patients who were euthanased, 21 of them were in breach of the legal requirements. This does not mean there was outright murder in all of these cases. We do not want to be alarmist about these either. But if you look at the breaches, they are quite significant. In 18 cases a second doctor was not considered independent. What was happening there, was it haste? "We need to find another doctor." That is 18 of them. In two, patients were not considered at the end of life by the review. Again, how do we determine end of life, how do we determine incurable and how do we determine terminal. In one case there was a failure to prove that the patient had a serious, incurable illness. That in itself is one thing, but what happens after these breaches? In Canada none of these was referred to as possible homicides. The safeguards were there, but once there was the breach there seems to have been a vacuum after that. They are not being referred on anywhere. Again, it is a different jurisdiction, I do accept that. But in Belgium there too, I think it was in 13 or 15 years—I can provide the exact statistic—not a single case has been reviewed, which again tells me that either a system is working perfectly, and as we know even the best designed systems often do not, or there is not rigorous investigation.

Mr J.E. McGRATH: What you have done is raise something for our committee. You said before that you did not think we should be going down the path of what do we do if it does come in, but these are the things that we need to consider—that the safeguards are workable and that they can be managed and a proper process put in place. In the cases you have raised here maybe the proper

processes were not put in place or maybe there were circumstances that happened in a hurry and they could not find the doctor who was independent and they had to get someone else's second opinion or something like that. Do you think those sorts of things could happen?

Mr VAN der PLAS: Again, we would see that as a reason not to go down the path at all. Our position would be do not go down the path (a) morally, but even (b) with all the talk of appropriate safeguards, we believe that they will not be appropriate.

Mr VAN der LINDE: If I may also make a comment. Our position is that once any form of legislation is introduced, it becomes inevitable that you then start to head down the path of expanding that law and start to regress that law further. The way we view the law currently is that every human being has intrinsic value, we believe given by God because we are created in his image. If the law is to be just, it needs to respect and recognise that intrinsic value in every human being. As soon as any legislation is passed which classifies a certain group of human beings as eligible to be killed, then we are violating our nation's commitment to equality in front of the law because the natural progression from that is the logic of compassion—and that is the word that is used—is that if a life is better off dead in certain circumstances, what does it matter whether that person requests it or not? You start to head down a path by opening up that legislation immediately from a logical point of view from simple voluntary euthanasia or physician-assisted suicide along to voluntary euthanasia down towards non-voluntary euthanasia and even some cases of involuntary euthanasia as we are starting to see some examples in the Netherlands and Belgium. Do you understand where I am coming from there?

[2.00 pm]

Mr VAN der PLAS: If I could interact with the member on one more thing. I think this again is also partly the nature of our faith, is that you see these sets—because we believe God made the world and that he controls everyone, we believe that these rules apply even if people do not believe in him. Again, in the day and age we live in, that sounds like a really arrogant thing to say. Would I love for everyone to be a Christian? Yes. Can I force them to be? No; absolutely not. But that does not take away my desire that everyone would be and, by extension, would follow God's laws. That is kind of where we are coming from in this position. We realise that as a government, especially as our world and society becomes more fractured—it is less homogenous than it was in the past—that makes government's task very difficult. We fully understand that, because you have to govern for everyone. We get that that becomes difficult, but our overriding world view would still be: God gives us these laws. He says: do not murder. That applies for everyone; not just a set of laws for Christians and a set of laws for others. If that makes sense.

The CHAIR: By extension, what do you think about the potential for current failures in the system of palliative care as it exists with the reliance on double effect, terminal sedation, futility and withdrawal of treatment? They rely on medical practitioners providing a prognosis and a time frame, and no system is perfect. That is the current situation, so can you just describe to me why that is different?

Mr VAN der PLAS: I think recognising that a system is not perfect is great. That is what motivates change: when we recognise that something is not ideal, then we want to invoke change. Again, we are not palliative experts; I would leave those sorts of comments to the people who I am sure you have spoken to you about that. But, again, from our point of view, by all means let us do whatever we can to rectify those failures, but let us not go down the path of rectifying those values by allowing intentional acts that end someone's life.

The CHAIR: We have had some of the strongest evidence we have received, and a lot of it, from older people who want access to voluntary assisted dying, and they want to have that choice. I invite you to comment on that.

Hon ROBIN CHAPPLE: Are they misguided?

Mr VAN der PLAS: That is hard for me to say. I think it is regrettable that people look at the future. I think it is understandable that we look at the future and we fear what is going to happen, because we, as a people, are used to a high degree of control over our lives. I think that is a change in society too. People look at the future and they say, "What's that going to mean? What's going to happen when I can't care for myself anymore?" People approach that with fear. I have close friends who have disabilities. They already cannot do a lot of those things themselves, so they look at this and say, "This is what we deal with on a day-to-day basis already." I would do whatever we can to mitigate those fears. If it was up to us, say, "We will do whatever we can for you. We'll help you to overcome it, but we will not end your life even if you want to", which is a standard we already apply to our society. I used to work on 000 for two years for the police. I have spoken to countless people in various stages of suicide. It is awful because in their mind they want to end it; they cannot see a way out. But I think our job as a society at that point, which we already do, is we get behind them. We say, "You can't see a way out, but we're going to be there for you. But we are not going to end it", because the alternative—this again from Canada has happened, where a woman in one of the churches that we know there, she is in her 80s. She went to hospital with, I think, pneumonia or something like that—I can clarify that. When her family had left, she was spoken to privately, "Just so you know, if you want to end it all, you can." This lady is scared. Are we going to have a perfect system? No. But what is the worst of the two evils? We would say a system where people fear they could die. That is far, far worse.

Hon NICK GOIRAN: Further to this, picking up on this point about the far worse of the two systems. I notice in your recommendations—recommendation 7 is quite, I suppose, novel or new. Somebody this morning asked me, "The committee has had so many hearings, are you hearing anything new?" I thought it was probably a fair question to ask. I can say with sincerity that your recommendation 7 is not something that we have had put before us before. Can I get you to elaborate on this risk assessment that you say that the committee should undertake?

Mr VAN der PLAS: This is probably somewhere out of left field. It, again, comes from a personal story. When I was a volunteer in the fire and rescue service, one of the things we had was this whole idea that if there is a bushfire, do people stay and defend their homes or do they go? That is the question: what do you do? What you do is you say, "In each situation, whether I stay and defend or whether I go, what is the best outcome and what is the worst outcome?" The best outcome if you stay and defend your house, is that the fire passes your house or you manage to defend it and your house is safe. Whether you go, the best outcome is actually same. The fire passes your house; the fire brigade gets it; it is all good. What is the worse outcome in each state? The worst outcome if you go early, is that your house is burnt up. You are safe, but you lose your house. What is the worst possible outcome if you stay and defend? The worst outcome is you die. On that basis alone people are told: go. At least your life is safe. If you transpose that across to assisted dying, the best possible outcome for every Western Australian if we do not legalise assisted dying is a peaceful death—that is the best possible outcome in both cases. What is the worst possible outcome? The worst possible outcome if we do not allow assisted dying, is that some people may die a painful death. We grant that. What is the worst possible outcome if we do allow assisted dying? The worst possible outcome is that someone who does not need to die inadvertently does. That is what we mean by the risk assessment. Under that matrix, the worst possible outcome is far worse under assisted dying. That

is a death that did not have to occur or should not have occurred. There are stories coming out of places like the Netherlands where that is happening.

Hon NICK GOIRAN: Thanks for the clarification. As I said, it is not something that we have heard before. I think it has got merit. With regard to your recommendation number 6, this goes somewhat to your point earlier about trying to compare like for like. You did explain to the committee why you have emphasised Canada as a jurisdiction in terms of doing analysis of whether safeguards hold or fail. Has your organisation had a look at any of the safeguards under the Northern Territory legislation that was in Australia for a period of time?

Mr VAN der PLAS: I believe that was in the 90s, wasn't it? No, we have not. We are aware that it existed. I think that is the first example of euthanasia in Australia; but, no, we have not looked into it in detail.

Hon NICK GOIRAN: In terms of comparing like for like, you have encouraged us to look at Canada and explained why. Do you think it holds that we should be looking at the Northern Territory experience then?

Mr VAN der PLAS: I would say that we should be looking at every comparable jurisdiction. The reason that Canada came up in our mind is that Canada is very topical. As reformed churches, there are a lot of them in Canada as well so we sort of have interpersonal contact. My fiancée is from one of these churches, so that is sort of what you hear about. It is closer to home and that is partly why it came up. Also because it has gone down that path and has received federal approval to do so. Also there you have a system that is, I think, probably of greater weight, so to speak, than something that happened for a short period of time in one territory. Here you have a countrywide system, which gives you more data and it is current data that you can examine. Again, that is another reason why I think Canada is worth looking into closely.

The CHAIR: Your submission states that examples exist in overseas jurisdiction of individuals being denied chemotherapy for cancer because it is deemed too expensive in relation to the cheaper cost of euthanasia medication. Can you provide some evidence of that?

Mr VAN der PLAS: I can. Again, bear with me, unless one of your members has found it first. It related to a managed care plan in the United States; that is where it came from. I just want to find it in the report.

[2.10 pm]

The CHAIR: We can take it on notice.

Mr VAN der PLAS: I was going to say that, unless we find it quickly. We are happy to take the question on notice if you want more detail, but the brief answer is that there was a person in the United States who was denied chemotherapy by, I think it was, a managed care provider—it is a different insurance system to Australia—because the cost was deemed to be excessive and euthanasia was cheaper. If you would prefer us to take it on notice and provide more information, we are happy to do so.

The CHAIR: Was that in a jurisdiction where voluntary assisted dying was legal?

Mr VAN der PLAS: Yes. I believe it was Oregon, but I am happy to take it on notice.

Hon Dr SALLY TALBOT: I believe that the reference there, if I have read it right, was to the *Daily Mail*. Have you got an academic reference for that or is it just a newspaper article?

Mr VAN der PLAS: It would be just the newspaper article if it is American.

Hon ROBIN CHAPPLE: It was the *MailOnline*.

The CHAIR: Advance health directives are also part of our inquiry. Is your congregation advance-health-directive literate, if you like?

Mr VAN der PLAS: I do not think I am. Are you?

Mr VAN der LINDE: No.

Mr VAN der PLAS: Did your parents ever do that sort of stuff? Did it come up?

Mr VAN der LINDE: Possibly.

Mr VAN der PLAS: Again, it would be an individual thing, provided it does not cross that line that at a certain point it would make it all end.

Mr J.E. McGRATH: Do you get many people in your church or churches who might go to people like yourself and say, "When the time comes I would like to end it. I don't want to suffer"?

Mr VAN der PLAS: No, I have not heard that from anyone.

Mr J.E. McGRATH: You have never had that from anyone?

Mr VAN der PLAS: No. I have certainly heard people express that it is awful to go through—absolutely. I can only speak for my grandfather and my uncle, both of whom I saw in the days leading up to their death. They certainly had lost their dignity—there was no doubt about that. They were bedridden, but they were at peace. It is interesting that even sometimes people who—this again might sound funny to say—but during their life you do not always hear them talk in a spiritual way, or talk about God, but then when death comes, you see a peace. I saw that in my uncle. It is this peace that God will call me home when he is ready. That gives them strength to carry them through that discomfort. I have never seen someone in a Reformed Church say, "When the time comes, just end it all."

Hon ROBIN CHAPPLE: Can I just go back to advance health care directives. They are quite common, though not as common as I think people would like. What they enable people to do, quite a way out, is to say, "If I get to this stage, I do not want any further medication, or if I reach this stage and I suffer a cardiac arrest, I do not want to be resusced." There is a problem that is being created. There is not a central registry. There is a bit of an issue around that. Quite often we have an ambulance roll up and they have not seen it, so they resuscitate. What is your view about that? You have not experienced them, but that is the nature of an advance care directive—if it gets to this point, I do not want any further support or I do not want to be resusced or these sorts of things. So it is not an active intervention; it is a prohibition of further activity to sustain my life. Can you give me your views around that?

Mr VAN der PLAS: I personally find that a difficult question to answer. Again, there are multiple factors there. There are the family's wishes. This comes up in organ donation where someone says, "Yes, I want to donate my organs," and the family, I think, can actually override it. It is very complex. If someone has a car accident and there is such an order that exists, we would not know about it and resus might still be attempted. It is a very difficult area. Again, our overriding factor as a Christian is that we will never allow an action which determinably ends our lives.

Hon ROBIN CHAPPLE: You mentioned organ donation. What is your issue around organ donation of somebody who is deceased? It is still part of the end of life.

Mr VAN der PLAS: Sorry, the moral dilemma so to speak? I think our fear is that if I am an organ recipient, am I benefiting from an act that I cannot hold up in my conscience? I would find it very difficult to receive an organ from someone who has undergone euthanasia.

Hon ROBIN CHAPPLE: Generally, or only somebody who has actually taken proactive steps?

Mr VAN der PLAS: Only proactive steps. No, we are not against organ donation. No; not at all. Organ donation is a wonderful gift and we support that wholeheartedly.

The CHAIR: My colleague mentioned earlier the issue of protecting practitioners who have particular religious views in any legislation. Do you think it is reasonable that a large part of the community would expect to be protected from religious views in legislation?

Mr VAN der PLAS: Protected from religious views in the sense of—can you give me an example of how that might work?

The CHAIR: This is probably a good example. The evidence that we have had from submissions is about people wanting autonomy, which is a recognised medical principle—a patient's right to autonomy—and that access to ending their own lives at a time of immense suffering and pain, where there is no hope of recovery, would be their right, and they would like legislators to protect that right from those who do not want to allow that right.

Mr VAN der LINDE: I think this is where you come to a real clash of world views or clash of ideologies. How, as legislators, do you account for that—both world views? That is very difficult. You see this same discussion happening in, for instance, the same sex marriage debate and other areas where pastors are questioning whether they are going to have to be forced to marry against their conscience. The same question is very relevant for doctors, should any legislation come in—whether they are going to have to act against their conscience. Obviously our point of view is that everything must be done to protect religious freedom, not just in necessarily one specific capsule or compartmentalised area of life, but religious expression to be able to practice and say what you believe in public.

Mr VAN der PLAS: With respect—again, it may be controversial to say this—we would also challenge this notion: do we have an inherent right to determine the end of our lives? You or I could be killed on the way home now and we would have no say in it whatsoever. So this idea that there is some inherent right to determine the end of our life, that we would also respectfully question. Does such a right exist? Autonomy? Of course, to a point. How far do we take that? Do we have a right to determine how it is going to happen? What is that right based on?

The CHAIR: Are there any other questions for our witnesses? 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 of 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. The committee will write to you with questions taken on notice during the hearing. Thank you both very much for appearing today; it is much appreciated.

Hearing concluded at 2.17 pm

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