Chisholm Health Ethics Bulletin

Vol 18 No 4 Winter 2013

Australia's New Dietary Guidelines

The National Health and Medical Research Council released a new set of dietary guidelines on 18 February 2013, to help ensure that Australians continue to make healthy food choices based on the best available scientific evidence. Unlike the 2003 guidelines which were based on nutrients, these guidelines are based on food and food groups. The guidelines encourage the consumption of a varied diet and physical exercise. They also encourage the limiting of energy-dense nutrient-poor food. By making these food choices, we can help to reduce our risk of diet-related disease.

The *Australian Dietary Guidelines 2013* is two hundred and ten pages long. There are eleven appendices covering a diverse range of topics, such as the social determinants of health, food sustainability, literature review questions, as well as physical activity guidelines. One thousand, one hundred and twenty-eight references are cited throughout.[1] As well, there are a number of supplementary resources that accompany the guidelines, which are located on the National Health and Medical Research Council (NHMRC) website at *http://www.nhmrc.gov.au/guidelines/publications/n55*. They are: a forty-five page summary, an educator's guide, as well as documents that explain the process of review undertaken to establish the 2013 Dietary Guidelines. The guidelines are supported by a website *Eat for Health*, *www.eatforhealth.gov.au,* which provides information to support the development and maintenance of healthy lifetime eating habits.[2] The iconic food pyramid has been replaced and food groups are now presented in a plate format, with discretionary foods placed outside the plate.[3]

There are five guidelines. The first describes how to achieve and maintain a healthy weight; the second encourages enjoyment of a wide variety of food from five main food groups; the third examines foods which we should limit; the fourth encourages breastfeeding; and the fifth provides information on food safety. Infant feeding guidelines were released at the same time. There is also some practical advice on how to enjoy those foods that are healthier for us, and on how to limit, but enjoy, those discretionary foods that can have a damaging effect on our health.

Evidence utilised in the development of the dietary guidelines was graded from A to D in line with NHMRC protocols. Grade A indicates that the body of evidence can be trusted to guide practice; B may be trusted in most situations; C provides some support for the recommendation, but proceed with care; while for D the evidence is weak and any recommendation must be applied with caution. A minimum of five quality studies was required for evidence to be graded.[4] The evidence provided to support each guideline is listed with the grading in the Guidelines.

Aboriginal and Torres Strait Islander people,[5] infants, children and adolescents, older people, pregnant and breastfeeding mothers as well as those with lifestyle specific diets are provided with advice at the end of many of the sections of the guidelines. With cardiovascular disease, type 2 diabetes and different cancers often being the result of different dietary choices, explanations are provided throughout the guidelines as to how food choices can help with minimising the risk of these and other food-related diseases.

The guidelines are not applicable for those who require specialised dietary information for a medical condition, nor are they applicable for the elderly who may be at risk of malnutrition.[6]

This article continues with an examination of the main sections of the *Australian Dietary Guidelines 2013.*

Introduction

Diet is probably the most significant behavioural risk factor which influences our health and wellbeing, but which can usually be controlled. Several of the diet-related chronic diseases which are a major cause of death and disability amongst Australians are preventable.[7] The diet of many Australians consists of energy-dense but nutrient-poor foods, which also tend to be high in saturated fats and have added salt or refined sugars. Food such as vegetables, fruit and wholegrain cereals are nutrient-dense foods. Dietary recommendations can direct people to the more ideal foods to consume for better health; however, Australians also need to focus on the quantities of food consumed. A body weight

IN THIS ISSUE

gain can be the result of an excessive food intake even if it is nutritious. Energy/kilojoule consumption is encouraged to be balanced against the amount of energy required.[8] The Australian Government media release for the dietary guidelines noted that Australia is facing an obesity epidemic and the consumption of food with little nutritional value is one of the contributing causes.[9]

The Australian Guide to Healthy Eating is a tool within the *Eat for Health* resources which adapts the scientific understanding of food composition and nutritional requirements for the best health outcomes into an accessible guide. In the *Eat for Health* resources, foods are grouped together according to their nutrient contribution and their type. Examples are provided for the proportion of the five food groups that should be consumed daily. The quantities suggested were determined by a *Food Modelling System* where the nutrient requirements are based on age, gender, height and activity level.[10] Foods represented in the five groups, reflect many foods commonly eaten by Australians. The program provide a choice of foods to choose from within each group, considers the food supply, and provides options to help with food choices to move towards healthier eating.

… Diet is probably the most significant behavioural risk factor which influences our health and wellbeing, but which can usually be controlled....

The World Declaration on Nutrition in 1992 states that "access to nutritionally adequate and safe food is a basic individual right."[11] To lessen the risk of increasing health inequalities by the endorsement of hard to access or costly foods, societal factors that can influence health and nutritional status were considered in the preparation of these guidelines.[12]

Not all Australians have the choice to choose the healthiest food options. This is shown in the life expectancy of different social groups as well as in the rates of diet-associated disease, and the access to and use of health services. These health inequalities are often determined by factors unrelated to the health system, such as the unjust sharing of resources in our communities. Diet and health can be determined by an interconnection of a person's education and income, their culture, their access to food, their social situation, or whether they are geographically isolated. The connection continues that poor health can influence a person's ability to earn an income, and thus their access to quality food, as they may not be able to buy or store perishable food. The foods most readily available often belong in the discretionary food choices group.[13] Statistics collected by the Australian Bureau of Statistics and the Australian Institute of Health and Welfare show a death rate that is 70% higher in the lowest socioeconomic group for those aged between 15 and 64 years. This is reflected in a higher rate of type 2 diabetes and cardiovascular disease for this group.[14] A social gradient related to the distribution of diet-related chronic disease also exists. This is associated with the economics of food choices where value for money can be tied to maximising the energy within a food. Energy-dense, nutrient-poor foods cost much less than nutrient-rich foods. Food security is the ability to access safe, nutritious, affordable food. Thus a family can experience food insecurity when they are unable to purchase food or when they run out of food. Approximately 5% of the Australian population suffer food insecurity each year. This can be related to the rising cost of food in Australia. Milk and milk products intake increases with social advantage, as does fish and seafood consumption. However, the intake of sugar products decreases with social advantage.[15] Appendix A discusses these inequalities in more depth, in particular examining different at-risk groups within our communities.[16]

Guideline 1 – Achieve and Maintain a Healthy Weight

This guideline encourages the maintenance of a healthy weight through being physically active and consuming adequate nutritious food to meet energy requirements. Quantity is as important as quality. Obesity has become a global concern. In 2007-8, 2% of Australian adults were underweight, 37% were healthy weight, 37% were overweight, and 25% were obese. Additionally, 21 to 25% of children and adolescents were overweight or obese. This included 5 to 8% who were obese.[17]

The dramatic global increase in weight gain suggests that although genetic factors may be involved, socioenvironmental factors are contributing significantly, including the availability of cheap energy-dense nutrient-poor food along with a dependence on cars, limiting incidental activity. The 2007-8 National Health survey found 37% of adults exercised sufficiently to achieve a health benefit. Overweight and obese people, are at a greater risk of developing a number of diseases, including type 2 diabetes, cardiovascular disease, and hypertension.[18]

These guidelines do not encourage food restrictions other than discouraging an excessive consumption of energy-dense and nutrient-poor discretionary foods. Nutritious food consumed needs to be balanced against physical activity performed and portions adjusted as required. Childhood obesity can lead to weight issues in adult life. Older people are encouraged to eat nutritiously, and to keep physically active to maintain muscle strength and a healthy weight.[19]

Guideline 2 – Enjoy a Wide Variety of Nutritious Foods from the Five Groups Every Day

Listed under this guideline are the five recommended food groups. They are:

1. vegetables which includes legumes/beans
2. fruit
3. grain foods which includes breads, polenta, pasta, rice, oats, noodles and quinoa
4. lean meats which also includes poultry, fish, eggs, tofu, as well as nuts and seeds, and
5. milk, yoghurt and cheese which should mainly be reduced fat

There is also a recommendation to drink plenty of water. By including a wide variety of choices from these five groups, nutrient requirements are likely to be met, and health benefits will be greater than a restricted diet.[20] When a food

budget is tight, whole unprocessed foods in season can be an economical choice, and if fresh produce is limited, canned foods low in salt and sugar or frozen vegetables can be used as a nutritious alternative.[21]

Over the past decade, there has been increasing evidence of the health benefits of a varied nutritious diet. Dietary variety also benefits by diluting some of the potential toxicants that occasionally occur naturally in some foods. Risk is also minimised with careful processing, cooking and storage of food. This is examined further in guideline 5.

Since 1995, the cultural diversity of Australia has provided a wider variety of foods; however, the demand for fast or convenience foods has also increased along with social and economic conditions resulting in an increase in the consumption of energy-dense nutrient-poor foods. The information within this guideline explains the evidence available to verify why consuming a variety of foods from each food group is the healthiest option. Food choices can contribute to a person's risk of developing cardiovascular disease, type 2 diabetes, or excessive weight gain, as well as the risk of other cancers.[22]

The recommendation is that at least five 75g serves of vegetables are consumed each day, as well as two 150g serves of fruit. The amount for children and adolescents varies dependent on gender and age. At least four to six serves of cereals and grains, preferably wholegrain are recommended each day. Again, the amount for children and adolescents varies dependent on gender and age. The lean meats group is by convention seen as the protein rich food group, but the variety of foods now in this group widens choice to include other protein options. Fish is included in this group. The evidence regarding the health benefits of consuming fish have increased over the last decade. Legumes are important for those who enjoy a vegetarian or vegan diet but also offer many benefits to all Australians, and the guidelines suggest at least a minimum of two serves per week. At least two serves of milk, yoghurt, cheese and alternatives should be enjoyed daily. For those over two years of age and younger than seventy years, reduced fat varieties are recommended. Guidance is offered for those who are lactose intolerant.[23]

Water is the preferable option to drink. Soft drink has been associated with weight gain and dental caries. The NHMRC has developed guidelines for tap water standards to determine safe drinking water.[24]

Guideline 3 – Limit Intake of Foods Containing Saturated Fat, Added Salt, Added Sugars and Alcohol

Practical information is provided in this guideline on choosing a variety of nutrient-rich foods, and how to avoid or limit discretionary food and drink.

The link between cardiovascular disease and diet is a topic of constant research. Over the last sixty years, evidence has been growing that the intake of foods with a high saturated fat content is linked to high blood cholesterol, and that limiting these foods will help in reducing serum cholesterol. These foods can be replaced with foods that contain monounsaturated and polyunsaturated fats. This will reduce the risk of cardiovascular disease but requires a whole diet approach rather than an individual food approach.[25]

Fats are categorized according to their chemical structure. There are trans fats, saturated fats, monounsaturated fats, and polyunsaturated fats.

Trans fats (an unsaturated fat that behaves like a saturated fat)[26] can be found in dairy products and meat from some animals as well as hydrogenated vegetable oils used to make particular processed foods. Trans fat intake in Australia is generally low.[27] Fats can make our food more appetizing, and some unsaturated fats are essential for health. Saturated fats can be replaced with mono and polyunsaturated fats options, for example:

- Sour cream or coconut milk can be replaced with light evaporated milk or plain yoghurt.
- A commercially baked or fried food takeaway can be substituted with a bread-based food.
- A salad or vegetables make a healthier side order rather than chips.
- Instead of deep frying foods, sauté, stir fry, grill or bake.
- If oil is required, choose unsaturated oil.[28]

The Heart Foundation welcomed the amendment from the 2003 guidelines (which recommended low fat foods) to a recommendation to replace foods with bad fats to foods with good fats.[29]

… The recommendation is that at least five 75g serves of vegetables are consumed each day, as well as two 150g serves of fruit....

Some salt intake is necessary as sodium and other electrolytes are required by the body to maintain extracellular volume and serum osmolality. However, most Australians consume too much salt in their diets, mostly in the form of processed foods. Salt enhances flavour, as well as being a preservative. It is often present in processed foods. Training taste buds to appreciate less salty foods, reading labels to guide purchases of foods that contain lower salt, choosing products with no added salt, and limiting intake of processed foods such as processed meats and high salt breakfast cereals can help with reducing salt intake. In both adults and children, blood pressure can be reduced by a decrease in salt intake. A lower intake of salt can also reduce the risk of heart disease and stroke.[30]

Sugars are carbohydrates and occur naturally in many foods in the form of fructose, sucrose, lactose and glucose. These naturally occurring sugars are known as intrinsic sugars and can be found in fruit, vegetables and dairy products. Extrinsic sugars are those that are added to foods. They are often used as a sweetener, flavour enhancer or a preservative. Although sugars do provide a readily absorbed source of energy, added sugars have the potential to increase the energy content and decrease the nutrient density. Tastebuds can be trained to rely on a lower level of sweetness in foods by:

- reducing the number of sugars in a 'cuppa'
- replacing sweetened foods with fruit

- drinking chilled water with lemon or mint added for variety instead of sugary drinks

Sugar and its impact on health has been a contentious issue for a number of years. Although not linked to cancer, added sugars are now linked to weight gain and dental caries.[31]

Alcohol is a unique substance in that it is both a food which is high in energy as well as a drug known to affect brain function. In 2009, the NHMRC released a new set of Alcohol Guidelines which offers guidance on reducing the harm caused by the over-consumption of alcohol.[32] For healthy adults, no more than two standard drinks[33] a day is the recommendation. For those under 18, not drinking at all is recommended. Not drinking alcohol is also the best advice for women who are planning a pregnancy, or who are pregnant or breastfeeding. Alcohol begins to affect the brain within 5 minutes of consumption with blood alcohol levels peaking after 30 to 45 minutes. It takes the liver at least an hour to clear one standard drink from the body and this is dependent on liver size, body mass and individual tolerance to alcohol. Alcohol is often enjoyed with meals; however, the recommendation is that if you do choose to drink limit your intake.[34]

Guideline 4 – Encourage, Support and Promote Breastfeeding

The World Health Organization states: "Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants."[35] Similarly, the NHMRC places a great emphasis on breastfeeding, as encouragement to breastfeed has been part of the dietary guidelines since their introduction in 1982.[36] Much evidence has been accumulated to encourage breastfeeding, with many advantages seen for both mother and baby during infanthood and later in life. A breastfeeding mother should eat a wide variety of nutritious food.

Six months minimum is the suggested optimal time for exclusive breastfeeding for a full term infant, with no risk factors documented for the infant or the mother. Evidence has shown that with antenatal and perinatal support breastfeeding rates can increase. The lowest rates of breastfeeding in Australia are found in women in the lowest socioeconomic quintile. If a child is not breastfed, infant formula should be used as a replacement until the child is at least 12 months of age. Solid foods can be introduced from approximately six months of age.[37]

Guideline 5 – Care For Your Food; Prepare and Store it Safely

There are an estimated 5.4 million cases of foodborne illness every year in Australia, with 20 to 40% originating in the home. The annual number of work days lost to foodborne illnesses is estimated to be 2.1 million days.[38]

Pathogenic micro-organisms can be present in foods, and multiply to an infective dose if foods are not stored or prepared safely. However, some foodborne illnesses can occur when pathogenic numbers are small. Foods often at risk are those that contain raw or cooked meat, dairy products, seafood, cooked rice and pasta, salads and processed foods containing eggs or other protein-rich food. Foods such as sandwiches that are made with the aforementioned foods should be cared for appropriately. The most common foods associated with foodborne illnesses in Australia are meat, seafood, and eggs.

The leading sources of food contamination are inadequate cooking, improper holding temperatures, contaminated equipment (e.g. knives, cutting boards, dishcloths, kitchen utensils, preparation areas), unsafe raw foods, and the poor personal hygiene of food handlers (e.g. inadequate hand washing particularly after handling contaminated raw food or not washing hands properly after visiting the toilet, blowing noses, changing nappies, or touching animals). Some fresh fruit and vegetables may also be contaminated through farming practices or soil contamination. Any open cuts or sores should be covered with Band-Aids prior to food preparation. When travelling for more than half an hour, store perishable foods in an insulated bag with an ice pack. Risks can also be decreased by keeping fridges and freezers clean, not allowing perishable foods to deteriorate, and storing left-overs for a minimum time.

Factors such as temperature, pH, protein and water content can affect the growth of microorganisms in food. Most bacteria multiply between the temperatures of 5^0C and 60^0C. Some bacteria can reach an infective dose within 4 to 6 hours; thus, refrigeration can slow bacterial growth and the rate of chemical change in food. Reducing the time that frozen food is at room temperature, will also minimise the risk of microorganisms multiplying. Cooking most foods to at least 75^0C will minimise the risk of illness; however, cooking is not a guarantee of protection against illness as some bacteria are encapsulated in a spore providing them with protection against heat. Cooling cooked foods to 60^0C then cooling them to 5^0C quickly by refrigeration should also reduce risk.[39]

Other precautions to minimise the risk of illness can be found on some food packaging. A use by date is a guide for the expected shelf life to ensure quality and safety of a product when it is unopened and stored according to instructions. A best before date is a guide as to how long a food should be kept before it may begin to deteriorate.[40]

There are a number of groups of people within our communities who are more susceptible to foodborne illnesses. The immune system may be suppressed in pregnant women. Therefore they can be more susceptible to illness, particularly listeriosis. The immune system of infants is not fully developed. Hence they can also be more susceptible to illness. Adults with conditions that reduce immune function and older people are also at risk.[41]

Environmental Impact of a Healthy Diet

The issue of the environmental impact of a healthy diet caused much controversy in the media prior to and after the publication of the 2013 Dietary Guidelines. The topic is addressed in the Guidelines in Appendix G, and a report on the public consultation on the topic is available on the NHMRC website.[42]

The Public Health Association of Australia (PHAA) in

their submission on the draft guidelines called for more on sustainability, suggesting that if we can't sustain a food supply then advice on eating nutritious food becomes redundant.[43] Conversely, Mick Keogh, Executive Director of the Australian Farm Institute, congratulated the NHMRC for concentrating on "the science of nutrition."[44] Keogh acknowledged that others were disappointed with this decision, but noted the variability in food production systems globally and argued that transposing one country's system to another is not appropriate.

Selvey and Carey in the *Medical Journal of Australia* raised concerns that food sustainability and the environmental impact of sourcing food had not been addressed appropriately in the 2013 *Australian Dietary Guidelines*. They expressed concern that the consigning of the issues relating to the environmental impact of food to an appendix diminishes the importance of the relationship of food sustainability to what we eat. They also highlighted that the Australian public have a little awareness of the link between food and its effect on the environment, and that the dietary guidelines would be a good place to start raising awareness.[45]

Amanda Lee, Chair of the Diet Guidelines Working Committee, responded to comments related to environmental issues in the guidelines that were raised by Michael Moore, CEO of the PHAA, on the Crikey Blog. Lee commented that the 2013 Dietary Guidelines are a tool to help formulate and inform policy rather than a policy in themselves, and the primary focus of the guidelines was the promotion of health and well-being and the prevention of chronic diet-related disease.[46]

Professor Warwick Anderson, the CEO of the NHMRC, also responded to the environmental concerns on Croakey, stating that more work is required on the environmental impact of food. He noted that the evidence available lacks the same rigour that had informed the main guidelines, and that most research on this issue has been in America and Europe where farming practices differ from those in Australia.[47]

However, Appendix G does provide some easy-to-follow behavioural changes that can lessen the environmental impact of our food supply. These include not eating to excess, not wasting food, eating a wide range of food from the five food groups, and limiting the foods listed in Guideline 3. Implementation of these strategies can help lessen the environmental impact of our food supply, while further research is undertaken to help us consider this issue further.

Conclusion

These new guidelines are based on scientific evidence which has been rigorously scrutinized. They provide accurate information on what we should be consuming and what we should be limiting. They emphasise the importance of good nutrition to our overall health and wellbeing.

The Australian Government has shown through the provision of supplementary resources that they acknowledge the importance of these guidelines in improving the health and wellbeing of each and every Australian. The website *Eat for Health* provides a wealth of information on how to implement changes into our daily food choices to help maintain a healthy weight and lessen the risk of diet-related disease.

We hope that this summary provides the reader with the impetus to check out these resources and to make healthy food choices.

ENDNOTES

[1] Australian Government, National Health and Medical Research Council, Department of Health and Ageing, "Australian Dietary Guidelines 2013," Australian Government, http://www.nhmrc.gov.au/guidelines/publications/n55

[2] Australian Government, National Health and Medical Research Council, Department of Health and Ageing, "Welcome to eatforhealth.gov.au Australian Dietary Guidelines," Australian Government, https://www.eatforhealth.gov.au/

[3] Australian Government, National Health and Medical Research Council, Department of Health and Ageing, "Eat for Health," Australian Government, https://www.eatforhealth.gov.au/sites/default/files/files/the_guidelines/n55j_australian_dietary_guidelines_poster.pdf

[4] Australian Dietary Guidelines, 112.

[5] Ibid., 105. It is recognised that Aboriginal and Torres Strait Islander people often suffer greater health inequities than other groups within our community.

[6] Ibid., 2.

[7] Australian Government, National Health and Medical Research Council, Department of Health and Ageing, "About the Australian Dietary Guidelines," Australian Government, http://www.eatforhealth.gov.au/guidelines/about-australian-dietary-guidelines

[8] Australian Government, National Health and Medical Research Council, *Eat for Health, Educator Guide* (Canberra: National Health and Medical Research Council, 2013), 1; http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/n55b_eat_for_health_educators_guide_1.pdf

[9] David Cooper, "Media Release, Translating the science behind eating well and staying healthy," Australian Government, National Health and Medical Research Council, http://www.nhmrc.gov.au/media/releases/2013/translating-science-behind-eating-well-and-staying-healthy

[10] Eat for Health, Educator Guide, 4.

[11] Australian Dietary Guidelines, 101.

[12] Ibid. [13] Ibid. [4] Ibid., 102. [15] Ibid., 102-4. [16] Ibid., 101-8.

[17] Ibid., 12-3. The most common assessment tool to measure healthy weights is the *body mass index (BMI). BMI* is calculated by dividing weight in kilograms by height in meters squared. Further information on *BMI* can be found in Appendix H (pp. 135-7) of the dietary guidelines or at the following web address*:* http://www.eatforhealth.gov.au/eating-well/tips-eating-well/tips-losing-weight-healthily

[18] Ibid., 17. [19] Ibid., 13-29. [20] Ibid., 31.

[21] Australian Government, National Health and Medical Research Council, Department of Health and Ageing, *Eat for Health Australian Dietary Guidelines Summary* (Canberra: National Health and Medical Research Council, 2013), 13; http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/55a_australian_dietary_guidelines_summary_131014.pdf

[22] Australian Dietary Guidelines, 32-5.

[23] Summary, 14-25. A guide to serve sizes can be found in the Summary document. Serve size is dependent on the food type.

[24] Australian Government, National Health and Medical Research Council, "Australian Drinking Water Guidelines 2011," Australian Government, http://www.nhmrc.gov.au/guidelines/publications/eh34

[25] Australian Dietary Guidelines, 68-73.

[26] Heart Foundation, "Transfat," Heart Foundation, http://www.heartfoundation.org.au/healthy-eating/fats/Pages/trans-fats.aspx

[27] Summary, 29. [28] Ibid., 31.

[29] Emma Bourke, "Low fat message out – good fat message in," Heart Foundation, http://www.heartfoundation.org.au/news-media/Media-Releases-2013/Pages/low-fat-out-good-fat-in.aspx
[30] Australian Dietary Guidelines, 73-6; Summary, 33.
[31] Australian Dietary Guidelines, 76-9; Summary, 32.
[32] National Health and Medical Research Council, *Australian Guidelines to Reduce the Health Risks from Drinking Alcohol* (Canberra: Commonwealth of Australia, 2009).
[33] Standard drink contains 10g or 12.5ml of alcohol.
[34] Australian Dietary Guidelines., 80-4.
[35] Ibid., 88. [36] Ibid. [37] Ibid., 87-96.
[38] Ibid., 98. [39] Ibid., 97-9. [40] Ibid., 99.
[41] Ibid., 99-100.
[42] Australian Government, National Health and Medical Research Council, "Australian Dietary Guidelines, Public Consultation Report, Appendix G: Food, Nutrition and Environmental Sustainability 2013," Australian Government, http://www.nhmrc.gov.au/_files_nhmrc/file/publications/adg_appendix_g_public_consultation_report.pdf; Australian Dietary Guidelines, 130-4.
[43] Public Health Association of Australia (PHAA), "Dietary Guidelines provide authoritative advice – but missed opportunities on breastfeeding and environment," Australian Healthcare & Hospitals Association, http://ahha.asn.au/print/17081
[44] Mick Keogh, "NHMRC Dietary guidelines stick to the science and leave sustainability to the experts," Australian Farm Institute, http://www.farminstitute.org.au/BlogRetrieve.aspx?PostID=312791&A=SearchResult&SearchID=5562296&ObjectID=312791&ObjectType=55
[45] Linda A. Selvey and Marion G. Carey, "Australia's dietary guidelines and the environmental impact of food 'from paddock to plate,'" *Medical Journal of Australia* 198, no. 1 (2013): 18-9.
[46] Michael Moore and Amanda Lee, "Sustainability and equity concerns should have been front and centre in the new dietary guidelines," Crikey, http://blogs.crikey.com.au/croakey/2013/02/19/sustainability-and-equity-concerns-should-have-been-front-and-centre-in-the-new-dietary-guidelines/
[47] Warwick Anderson, "NHMRC weighs into dietary guidelines debate," Croakey, the Crikey health blog, http://blogs.crikey.com.au/croakey/2013/03/05/nhmrc-weighs-into-dietary-guidelines-debate

All on-line resources accessed 9 December 2013.

Kerri Anne Brussen ✠

An Australian Video on Life Issues

This article gives the reader an overview of a DVD 'God So Loved the World: A Pastoral Series on Life Issues.' This DVD was produced by the Australian Catholic Life Council, a group established by the Australian Catholic Bishops Conference (ACBC) under the ACBC Commission for Pastoral Life. This article discusses the life issues covered in the DVD, which are abortion, euthanasia, and the reproductive technologies. Above all, it explains why it is necessary to develop a more positive pastoral response to these issues.

Many people whom we meet and care for today - not only in Catholic hospitals but in many other situations - may be confused about Catholic thinking on the life issues. If they have rejected what they *think* the Church has to say on these matters, it may be without ever having heard the whole story. In addition, a number of other people may be suffering from deep and unhealed wounds. Sometimes they find it difficult to raise such issues with us, fearful that they may be misunderstood, or even worse, judged and condemned. Despite all this, many of these people will be searching for help, love and reassurance.

How can we sensitively raise awareness of these issues, and the impact they are having on so many lives, or will have in the future? How can we let those who are suffering know that they can trust us, and that they can ask us for support, help and healing? In particular, how can we clear up common misunderstandings about abortion, euthanasia and the reproductive technologies?

It would appear that there is no simple answer! The ACBC Australian Catholic Life Council has become increasingly aware that all too often the Church's position on the life issues is not well understood, and sometimes has not been well presented. Sadly, some people think that the Church always says 'no.' They don't realise that this is only part of the story. Rather than judging or condemning people, the Church wants to raise awareness of these sensitive issues with love, compassion and life-affirming alternatives.

This DVD was produced for the Year of Grace and Faith, which provided us with new opportunities to reflect on these issues and on how we might develop a more complete, compassionate and positive message and a more effective pastoral response. It continues to provide us with new opportunities to clear up misunderstandings, and to encourage people to ask us for help − or, perhaps we might say, to let them know that it is safe to raise these issues with us and to ask us for help.

Abortion

The Life Council included the topic of abortion in *God So Loved the World* because they have become increasingly concerned about its impact on the lives of so many Australians. We have one of the highest rates of abortion in the world, with one in three women experiencing an abortion at some stage in their lives, and one in four pregnancies ending in abortion.

Most people find abortion a difficult and controversial subject, and one which often makes them very uncomfortable. Sometimes, this is because someone they know and love - perhaps a friend or family member - has been involved in an abortion, and they don't want to further wound them by raising the issue. Sometimes, they might want to help but just don't know how.

Over the last few years, we have learnt more about abortion and unplanned pregnancy from women who have lived through the experience. We have realised that all too often women feel like they have been abandoned or that they have no choice except abortion. Afterwards, they are left alone to cope with the grief and despair that follows.

Many people think that Church just says 'no' to abortion

and don't realise that, while the Church does oppose abortion, that is only the first part of the story. Many people would not realise that the Church has a positive and healing message, or that Pope John Paul II wrote beautifully and compassionately to women who have experienced an abortion encouraging them to seek help and healing. Perhaps they are not aware that in raising the issue of abortion, the Church wants to reach out to all those who have already experienced an abortion and to offer them our understanding, compassion, help and healing. We also want them to know that the Church is increasingly working to offer women genuine alternatives to abortion through new programmes like *Walking with Love.*

… If people have rejected what they* think *the Church has to say on these matters, it may be without ever having heard the whole story....

Through initiatives such as this DVD, we hope to open up a whole new discussion on the subject, and to encourage the Catholic community and all people of good will to reach out to those around us who might be facing an unplanned pregnancy or might be grieving as a result of a past abortion experience. They might be the elderly woman in a nursing home who is dying while still carrying the burden of an abortion so many years ago - a woman who might need a kind word and a sensitive priest or counsellor. Or perhaps we work with a young nurse or teacher facing an unplanned pregnancy alone, who would be grateful for our support and love in continuing her pregnancy. It is hoped that this DVD could be used in small groups to begin new conversations.

Euthanasia

Euthanasia can be a very emotional issue. People often fear suffering and dying, and therefore don't want to reflect on this topic until they are forced to, either through their own illness or because someone close to them is suffering. Our personal experiences of the deaths of those close to us can influence our understanding of end-of-life care. The ACBC Life Council chose to include the issue of euthanasia in their DVD as there continues to be much confusion around this issue.

Polls, opinion pages, the airwaves and lobby groups often claim widespread public support for euthanasia. Often people fear being in 'unbearable' pain, being over-treated and being 'kept alive by machines.' They think that legalising euthanasia would prevent this. Others are worried about being abandoned, losing their ability to care for themselves, and are fearful of needing or allowing others to care for them when they are no longer able to look after themselves. Since 1996 when Federal Parliament over-turned the Northern Territory's experiment with euthanasia, the so-called *Rights of the Terminally Ill Act*, there have been numerous attempts to legalise euthanasia or physician assisted suicide in the various state parliaments. When they have considered the issue carefully, these parliaments have resisted the push to legalise euthanasia. It is very likely however that euthanasia advocates will continue to agitate for the legalisation of euthanasia and physician assisted suicide. It is also possible that euthanasia will become legalised through a policy of not prosecuting mercy killing or through the legalisation of advanced directives requiring the withholding of food and water.

There is a great deal of misunderstanding about what euthanasia actually involves. *God So Loved the World* goes right to the heart of Catholic teaching on euthanasia, and simply explains what euthanasia is and what it is not. The DVD clearly outlines that euthanasia is a calculated act intended to hasten the death of a patient, even though with a merciful intention. It challenges the widespread claim that euthanasia is the 'most compassionate' response we can have when we encounter a suffering person. It explains why the Church opposes euthanasia, and explains why people still have a dignity that no sickness or distressing condition can take away. The DVD also explains the implications of legalising euthanasia, and how this could impact negatively on the lives of other people. It calls us to love the person who is lonely, anxious and vulnerable rather than abandon them to euthanasia. It challenges us to reflect deeply on this issue and calls us to a more noble response.

Euthanasia is a complex topic and every angle cannot be covered in a short DVD. However, viewers are encouraged to take another look at this important life issue. It aims to be a useful resource for teachers, parishes, pastoral associates, pastoral carers, and Catholics in general to open up discussion on the issue. It could also be a helpful resource for those involved in the formation of those involved in pastoral and palliative care. In addition, it is hoped that it might be seen by younger people via social media.

Reproductive Technologies

Some couples can have problems starting a family of their own. This can be a source of great sadness and heartache. Reproductive technologies can often appear to be a solution that seems to promise to provide couples with children. Many people will know couples - perhaps friends and relatives - who have longed for children of their own.

Many people can be surprised to discover that the Church has ethical concerns about some methods of reproductive technology. Sometimes couples struggling with infertility are encouraged to enter reproductive technology programs before they are aware of all the ethical difficulties that they could face as a result. *God So Loved the World* explains these ethical concerns and discusses the high number of embryos created, and how so many embryos are frozen, discarded, or destroyed. It discusses why this undermines the dignity of these tiny human lives, and tends to treat them as commodities. It explains why reproductive technology can harm the couple's relationship and their relationship with their children, when the child is not created from their bodily embrace but is created in a laboratory dish.

God So Loved the World makes it clear that the Church encourages couples to seek ethical alternatives to reproductive technologies. It further explains that when medical science works to find the source of the couple's infertility and works to treat it, the Church encourages such interventions. The couple may conceive naturally without the need for further medical intervention. In Melbourne, Mercy Hospital for Women offers a wide range of assessment, investigation and treatment options consistent with Catholic ethical standards. Other positive alternatives

to reproductive technology in Melbourne include *FertilityCare* and *Naprotechnology*, the Fertility Assessment Clinic at Manningham General Practice, and Natural Fertility Services Melbourne. Similar services exist around Australia. In addition, *God So Loved the World* sensitively reminds us that married couples still have a special dignity, regardless of whether they ever become parents.

God So Loved the World aims to open up a new conversation around reproductive technology and at the same time reaches out and offers pastoral care to those who are experiencing infertility, or who are suffering as a result of previous experiences with reproductive technology.

Conclusion

This new DVD *God So Loved the World* produced by the ACBC Australian Catholic Life Council aims to take the viewer to the heart of the matter, and to bring a more positive pastoral approach to the life issues. It aims to be a resource that we might use to encourage prayerful reflection and initiate conversations during the Year of Grace and Faith and beyond, so that together we might better bring the healing touch of Christ to those we meet. It includes interviews with Eugene Hurley (Bishop of Darwin and Chair of the Australian Catholic Life Council), Associate Professor Bernadette Tobin (Director of Plunkett Centre for Ethics), Susan Sullivan (Director of Mission Strategy at Catholic Health Australia), Fr. Robin Koning S.J. (a lecturer at Jesuit Theological College, Melbourne), and others. It should be helpful for teachers, pastoral carers, pastoral associates, priests, doctors, allied health professionals, students and all those with an interest in the life issues.

God So Loved the World is available via the website http://www.godsolovedtheworld.org.au Use the 'Donate' button at the top to order the DVD for $11.

Marcia Riordan is the Executive Officer of the Life, Marriage and Family Office, Melbourne. She is a member of the ACBC Australian Catholic Life Council.

Marcia Riordan ✠

Healing Experiences around Death

This article explores* Reflections of a Setting Sun: Healing Experiences around Death, *written by palliative care physician Michael Barbato. It considers caring for someone who is dying, and preparing for death. A major focus of this article is deathbed visions after which a dying person reports being visited by relatives or friends who have already died.

Dr Michael Barbato OAM has been a palliative care physician for more than two decades. He was Medical Director of Sacred Heart Hospice in Sydney, Medical Director of the Palliative Care Unit at St Joseph's Hospital in western Sydney, and Director of Palliative Care for the ACT. Since his retirement from full-time practice in late 2008, he has provided education and guidance about the journey of dying both to health professionals and the general community. Dr Barbato spoke at the Palliative Care Victoria conference in 2012,[1] and the Palliative Care Australia conference in 2013.[2] He is the author of *Reflections of a Setting Sun: Healing experiences around death* (2009), *Caring for the living and the dying* (2010),[3] and *Midwifeing Death* (2014). His website is http://www.caringforthedying.iinet.net.au/

I heard Michael speak in mid-2010,[4] and subsequently read *Reflections of a Setting Sun*. Whether we are a health professional, a person who is dying, or someone who is journeying with a dying person, Dr Barbato has much to teach us. In this article, I explore three of his insights. Drawing on Chapter 5 of *Reflections of a Setting Sun*, I offer a short reflection on how we might best care for someone who is dying. Drawing on the first four chapters of this book, I offer a longer reflection on what Dr Barbato calls "near-to-death experiences." And drawing on Chapter 6, I offer another short reflection on preparing for death.

Caring for Someone who is Dying

Compared with people from previous eras, many of us nowadays know very little about dying and death. Significant numbers of people now live for many years without personally experiencing the death of a loved one. The remarkable capacity of modern medicine to cure disease is one reason for this. Smaller families are another factor. We are also a death-denying culture which tends to hide from dying and death.[5] In this context, almost all of us would benefit from considering the observations in Chapter 5 of this book (pp. 152-178). Let me briefly highlight three of the most important:

Firstly, we must **try to recognise when the focus should shift from the hope of cure to journeying with a person who is coming to the end of their life**. If we wait too long to do this, we condemn a dying person to treatment which is futile and often burdensome. We thereby make their dying both more difficult and more unpleasant. As Dr Barbato notes, it is not easy either to know when this time has come or "to navigate the emotionally-charged terrain that accompanies this decision." Doing so requires "open and honest communication involving the medical team, the patient and the family." (pp. 157-158) We must all have the courage to raise difficult matters, to ask difficult questions, and to answer difficult questions honestly.

Secondly, we must **provide a healing environment for the person who is dying**. We may have to advocate insisting that they receive the best possible care. (p. 159) More importantly, we must be a healing presence with them:

Before visiting a dying relative or friend, "prepare yourself well for the time you spend with [them]. Empty yourself of emotional baggage… Be present, aware and real." (p. 162)

During the visit, really attend to the dying person. Draw upon all of your senses. Use your intelligence, and draw

upon all that you know about this person. Be prepared also to trust your intuition. People who are dying sometimes speak in metaphor or code. When a bushwalker talks about finding the trail, or a surfer talks about catching the wave, perhaps they are really talking about finding their way towards death. (cf. p. 177) Drawing upon your knowledge of this person, ask yourself what they might be feeling, or what they may need at this time.

There are many things you can do during a visit – for example, "read to them, read quietly, sit quietly by the bedside, tell them something, play music etc." "Use touch as a means of maintaining the connection." (p. 170) "Prayer, song, music, readings, loving words or tender touches all have their place," and "so too does silence." (p. 163)

Dr Barbato reminds us that an unconscious person is often very aware. He suggests that we think of them not as unconscious but as "superconscious" – that is, intensely aware of everything in their room and perhaps even of things beyond their room. (cf. pp. 166, 168) For this reason, "the 'rule' is that you always speak to the unconscious person and not about them." (p. 170)

After your visit, continue to reflect about what happened. It often takes time for us to make sense of what we have experienced. This reflection may guide us on our next visit.

Finally, **try to see this time of dying as a gift**. For the person who is dying, this time leading up to death can be incredibly healing as they reflect on their lives and as they draw close to the people they love. This time can also be a tremendous gift for those who accompany the dying person.

Near-to-Death Experiences

More than half of Dr Barbato's book is about what he calls near-to-death experiences. These include near-death experiences, deathbed visions, and other mysteries. Let me begin this section with a brief summary of what Dr Barbato says. (I hope that this necessarily brief summary will pique the interest of the reader to access and consider the more complete discussion of these phenomena in Dr Barbato's book.)

Dr Barbato discusses **near-death experiences** in Chapter 2 of this book. These near-death experiences[6] typically occur in life-threatening situations. Many people are aware of this phenomenon – in part because those who have this sort of experience often survive to tell the tale. As Dr Barbato notes, the quintessential near-death experience contains six core features:

i. a sense of peace, joy or serenity
ii. an out-of-body experience
iii. a sensation of passing along a tunnel, seeing bright lights, hearing music, a life review, and visions of pre-deceased relatives or others
iv. ineffability (i.e. a profundity of experience which cannot really be communicated to others)
v. a decision to return, and
vi. significant life changes (cf. p. 53, 55-64)

Some near-death experiences contain only some of these features, and we should consider the possibility of a near-death experience when even one of these core features is reported or observed.

Dr Barbato discusses **deathbed visions** in Chapter 1 of this book. When someone is dying, these deathbed visions may occur minutes or hours, days or weeks before death.[7] Far fewer people are aware of this phenomenon – in part because those who have this experience typically die and are therefore unable to continue to report what they experienced. Deathbed visions may contain up to three core features:

i. the appearance of pre-deceased relatives or friends, unfamiliar faces, religious identities, vistas or scenes
ii. gesturing by the patient towards something which no one else can see
iii. a state of peace and acceptance (p. 20, 21-27)

Here is just one example: Marcia was an elderly lady who had struggled to let go in her dying until she had a deathbed vision. She said to her daughter, "[L]ook at that beautiful yellow bird flying… I want to fly… I want to go home." She died peacefully soon after. (p. 22)

Dr Barbato discusses **other mysteries** in Chapter 4 of this book. These include out-of-body experiences, dreams, intuition, and after-death communication.

What is the cause of these near-to-death experiences? Dr Barbato discusses this in Chapter 3 of this book. There are three theories: the neurological theory, the psychological theory, and the transcendent theory. Let us look at each in turn:

The **neurological theory** holds that near-to-death experiences are simply hallucinations caused by malfunctions in the brain. Many people probably hold this view, though perhaps without really thinking it through. Dr Barbato accepts that neurological changes may contribute to some near-to-death experiences. He argues however that when we look at these phenomena more closely, we must conclude that neurological changes are not a complete explanation for near-to-death experiences. He notes for example that the clarity and significance of deathbed visions are very different from the maelstrom and chaos of drug-induced hallucinations or epileptic seizures. (pp. 89-94) While hypoxia may contribute to some of these experiences, many near-to-death experiences occur when the person is not hypoxic. (pp. 87-89) And indeed, "no single physiological change is regularly or consistently found in all near-to-death experiences, nor is any one change capable of inducing all the characteristic features of [these experiences]." (p. 86-87) For Dr Barbato, then, the neurological theory is not a complete explanation of near-to-death experiences.

The **psychological theory** attributes near-to-death experiences to "a form of dissociation designed to protect individuals during a life-threatening situation." (p. 98) Once again, Dr Barbato accepts that this defence mechanism may contribute to some near-to-death experiences. Once again, he argues that psychological defence mechanisms cannot be a complete explanation for near-to-death experiences.

The **transcendent theory** holds that at least some near-to-death experiences are mystical or spiritual experiences which provide glimpses – however limited – into a life beyond death. As Dr Barbato notes, many people (particularly those who have had such experiences) hold this view. This belief cannot be proven. However, especially given that the other theories do not provide a complete explanation of near-to-death experiences, this belief should not simply be dismissed.

Dr Barbato includes an important caution in this chapter. His clinical experience has taught him that being alert for deathbed visions and treating them seriously brings great peace and serenity to dying people and their families.[8] For this reason, he reminds us that what is most important about a near-to-death experience is not its cause but its personal significance. If we focus only on the possible causes of these experiences, "we will fail to smell the roses because we are too busy examining the roots." (p. 77)

Anthropology

Let me add some of my own reflections to this section. I begin with anthropology – that is, our understanding of the human person. Nowadays, many people have a purely materialistic concept of the human person. To the extent that they avert to mind or consciousness, spirit or soul, they hold that these phenomena simply emerge from the materialistic reality of biochemical reactions within the body or brain.

… being alert for deathbed visions and treating them seriously brings great peace and serenity to dying people and their families ....

This view, however, is not entirely adequate. It does not explain how the myriad of biochemical reactions within the human body come together as a single organism which each of us recognises as 'I.' As Dr Barbato notes, it also fails to explain "how the water of the physical brain [is] turned into the wine of consciousness." (p. 81) In any case, this purely materialistic view of the human person may be traced back to the Enlightenment which began in the seventeenth century.[9]

The anthropology from the Enlightenment is very different from the traditional anthropology which had hitherto informed Western civilization. This traditional anthropology is based upon both Greco-Roman philosophy and Judeo-Christian revelation. Something similar to this traditional anthropology has also informed other civilizations and other religions.

Inert matter such as rocks does not contain within itself a dynamism which causes it to change. On the other hand, living things – plants, animals and human beings – do contain a dynamism which causes them to change. It is the life principle. It is also the principle of organisation and development which causes these things to grow in a certain way into certain types of beings. Thus, a seed grows into a certain type of plant; a baby tiger becomes an adult tiger; and humans become beings who possess certain human characteristics. Traditional anthropology calls this life principle the spirit or soul. There are different types of soul. There is the vegetative soul of plants, the animal soul of the many animals, and the distinctly human soul. Traditional anthropology holds that the human soul is both rational and immortal. It is rational in that it forms a being which possesses some measure of rationality (or, in the case of people who are profoundly disabled, at least the radical potential for rationality). It is immortal in that traditional anthropology holds that the human spirit or soul endures and continues after bodily death.[10]

This traditional anthropology remains as part of Catholic belief. Catholic teaching holds that the human person is both body and soul – "a being at once corporeal and spiritual."[11] It also holds that our spiritual dimension does not simply emerge from our material dimension but instead is something which may be distinguished from our corporeality: "The Church teaches that every spiritual soul is created immediately by God – it is not 'produced' by the parents."[12] And of course Catholic teaching holds that the human soul "is immortal: it does not perish when it separates from the body at death."[13]

Catholic teaching does not require Catholics to believe that the soul leaves the body in near-death experiences, nor that deathbed visions involve visits by the spirits of those who have died.[14] By distinguishing body and spirit, however, Catholic teaching provides the metaphysical underpinnings for such a belief. Some Catholics will accept this spiritual explanation for near-to-death experiences; others will not.

In his own reflections on this matter, Dr Barbato does not draw upon either traditional Western anthropology or Catholic teaching. He draws instead on an anthropology proposed by a Buddhist physicist named Dharmawardena. This anthropology holds that:

> consciousness is not a property of the brain or a by-product of the brain's activity. In other words consciousness is not emergent. It is a non-material entity, capable of an independent existence but remaining within the brain while we are alive. It interacts with the brain while there is life but is capable of leaving the body temporarily…. The departure… is permanent with biological death… (p. 84)

The fact that I can find this vision of the human person in Catholic teaching and Dr Barbato can find something very similar in the writing of a Buddhist physicist reflects the ubiquity of the traditional anthropology. The transcendent theory of near-to-death experiences must be underpinned by something like this traditional anthropology. And, as Dr Barbato notes, when compared to the neurological theory, transcendent theory based on traditional anthropology "offers a radically different but no less plausible explanation for… near-to-death experiences." (p. 84)

Second Naïveté

French philosopher of religion Paul Ricoeur described the journey of belief from first naïveté through critical distance to second naïveté. This schema enables me to articulate my own journey of understanding about near-to-death experiences (and other matters of faith too). It may also help the reader to conceptualise and perhaps even to progress in their own journey of understanding. Let me begin by explaining what these three terms mean:

First naïveté is the simple, uncritical, accepting faith of a small child. When, for example, they are told stories of the healing miracles of Jesus Christ, children simply accept that this is what happened. They do not question this in any way.

As we grow older or wiser, we do ask questions. Did these things really happen? If so, why have miracles like these either ceased or become vanishingly rare? Why do so many people now suffer and die from disease? In these reflections, a sophisticated questioner might even draw upon what they have learnt about the way in which the Gospels were written. This stage is called **critical distance**. At the very least, in this stage we step back from faith. Perhaps we give up our faith, at least for a while. Some people become fixated at this stage and lose their faith.

Second naïveté is the recovery of faith. It is a different faith from that of first naïveté. It is aware of the questions, but it moves beyond the questions. Different people do this in different ways. One person may abandon the quest to understand what happened historically, and instead come to see the miracle stories as a symbolic promise that whatever happens God will look after them. Another person might recognise the limits of human knowledge. They come to see the arrogance of asserting with dogmatic certainty that miracles like these do not ever happen. Yet another person may experience a modern-day healing which defies explanation. This helps them to accept that similar mysterious healings may have happened long ago. Second naïveté is mature faith - a new and deeper faith which arises after naïve faith has been purified by critical thought.[15]

… Dr Barbato taught me to suspend disbelief, and to move beyond critical distance to second naïveté. I am now open to the significance of dreams and visions....

When I was a child, I accepted near-to-death experiences uncritically and literally. When I became an adult, I thought that I was now too 'clever' to hold such childish beliefs. Without really investigating the matter, I subscribed to the neurological theory. If someone tried to tell me about a near-to-death experience, I became adept at either ignoring them or changing the subject. I think now that I was fixated at the stage of critical distance. I must have missed out on many conversations which would have been both fascinating and deeply significant.

Dr Barbato taught me to suspend disbelief, and to move beyond critical distance to second naïveté. I am now open to the significance of dreams and visions. I ask about deathbed visions and after-death communication. When someone reports such an experience, I seek with them to discern its meaning. This has led to a number of deeply personal and deeply significant conversations. Who am I to say that these mysterious events cannot be real?

I invite the reader to muse on their own views about these phenomena. Some people will be open to the transcendent theory; others will not.

Preparing for Death

When someone knows that they are dying, the time which remains to them (be it long or short) is a highly significant period of their life. It is not just a few more months or days. It is instead a different period of one's life with its own challenges and possibilities. It is a time of drawing closer to the ones we love, and both celebrating and deepening these relationships. It may be a time of seeking to reconcile with those from whom we have become estranged. For believers, it is a time of drawing closer to God, and placing one's trust and hope in the Divine. It can also be a time of passionate experience "in which colors and sounds and smells are all more intense, in which smiles and laughs are irresistibly infectious, in which touches and hugs are warm and tender almost beyond belief."[16]

Above all, it is an opportunity to reflect on our lives, to understand more profoundly who we are, and to come to a deeper sense of the meaning of our life. We do this best if we do not leave it to the very end. And we can help someone who is dying in this journey of self-discovery by really listening to them and engaging seriously with them. "Dying, more than any other life event, presents us with the opportunity to grow, to change, to love, to appreciate and ultimately to experience the meaning of our existence." (p. 185)

Aware of all of this, Dr Barbato hopes that he will die not suddenly but after a period of illness and decline. I heard him say this in response to a question after his talk in May 2010. Because it is a rather unusual thing to hope for, some years later I emailed him to ask if this was indeed what he said. He replied, "I would feel cheated if I died suddenly. So yes a slow journey towards death is my preference."[17]

Dr Bill Bartholome was an American doctor who died of oesophageal cancer. Before he died, he wrote what has become a famous reflection on the positives of living in the light of death. He said that during this time "life doesn't seem like a box of chocolates; it seems like endless servings of incredibly rich chocolate mousse." Then he said:

> I wish that the 'final' chapter in all your stories will be one in which you are given the gift of some time to live with whatever illness proves to be your fatal illness.[18]

I am not sure if I am yet ready to hope and pray for a time of living with a fatal illness at the end of my life. If however such an experience did come to me, I think I know enough to see it as a gift and to look for the opportunities to grow and to change as I prepare for my death.

ENDNOTES

[1] "Quality Care Panel Discussion," Palliative Care Victoria, http://www.pallcarevic.asn.au/podcasts/quality-care-panel-discussion/

[2] Ross Murray, "Preparing for the end of life: Thoughts of a palliative care physician," ehospice, http://www.ehospice.com/australia/ArticleView/tabid/10688/ArticleId/6486/language/en-GB/View.aspx

[3] This is an updated second edition of his 2005 book *Caring for the Palliative Care Patient*.

[4] Giving a public lecture sponsored by La Trobe University Palliative Care Unit, Dr Barbato spoke about "Healing Experiences around the End of Life" at the Wheeler Centre in Melbourne on 5 May 2010.

[5] Ernest Becker, *The Denial of Death* (New York: Simon and Schuster, 1973). This book was awarded the 1974 Pulitzer Prize for General Non-Fiction. Becker argued that human civilisation is ultimately an elaborate defence mechanism against knowledge of our mortality. He also argued that the fear of death prevents us from living our life to its fullest.

[6] Fr John Flader recently discussed near-death experiences in the Sydney Catholic paper, *The Catholic Weekly*. He noted that one person who had a near-death experience was the founder of Opus Dei, St Josemaría Escrivá. While Catholics are not obliged to believe such accounts, Fr Flader commented that "we would be very foolish to ignore them." For all this, see John Flader, "Near-death experiences," *The Catholic Weekly* 13 July 2014, 18.

[7] In 2011, an article in the *Weekend Australian Magazine* interviewed a number of palliative care practitioners and researchers about mysterious end-of-life phenomena. Those interviewed included Dr Barbato, Helen Walker from Cabrini Health, and Associate Professor Mark Boughey from St Vincent's Melbourne. For this, see Kate Legge, "Letting Go: Uncovering one of life's last mysteries," *The Weekend Australian Magazine* 21-22 May 2011, 14-19.

[8] A recent study of patients in a hospice in New York reached the same conclusion. 59 patients were interviewed about end-of-life dreams and visions (ELDVs). 52 of them (88%) reported at least one dream or vision. These dreams or visions occurred while awake (16%), while asleep (45%), or both (39%). Nearly all ELDVs (267 out of 269) seemed or felt real to the patient. "Many patients reported dreams/visions of past meaningful experiences (28%) and reunions with deceased loved ones (72%) who often provided reassurance and guidance. Others reported themes of preparing to do somewhere (59%)." Significantly, these ELDVs brought "greater levels of comfort with approaching death." They were a profound source of meaning and comfort for the dying. For this, see Christopher W. Kerr et al, "End-of-Life Dreams and Visions: A Longitudinal Study of Hospice Patients' Experiences," *Journal of Palliative Medicine* 17, no. 3 (2014): 296-303 at 301-302.

[9] René Descartes (1596-1650), Thomas Hobbes (1588-1679) and Baruch Spinoza (1632-1677) were significant in the development of a purely materialistic view of the human person. Where traditional anthropology had conceived the soul as the life principle of the body, Descartes thought of Matter and Mind as two distinct substances. This is sometimes called Cartesian dualism because through it Descartes divided reality into two. Hobbes and Spinoza then rejected Descartes' concept of Mind, claiming that there was no such thing as a non-material substance and therefore no possibility of anything non-corporeal such as soul or spirit. Nowadays, this materialistic anthropology has become dominant, at least in academic circles. For more on this, see Kenan Malik, *The Quest for a Moral Compass: A Global History of Ethics* (London: Atlantic Books, 2014), 180-181, 182, 187-189.

[10] For two more accounts of soul and body, see Norman M. Ford, *The Prenatal Person: Ethics from Conception to Birth* (Oxford: Blackwell, 2002), 14-16; and Stephen Napier, "Brain Death: A Morally Legitimate Criteria for Determining Death?" *The Linacre Quarterly* 76, no. 1 (February 2009): 68-81 at 69-73.

[11] *Catechism of the Catholic Church, #362.* The account of the creation of the first human being in the second chapter of the book of Genesis notes the corporeal and spiritual dimensions of the human person when it states that "the Lord God formed man of dust from the ground, and breathed into his nostrils the breath of life, and man became a living being." (Gen 2:7)

[12] *Catechism*, #366.

[13] Ibid.

[14] Fr Flader also makes this point in his article on near-death experiences.

[15] For Ricoeur's account of these concepts, see Paul Ricoeur, "Conclusion: The Symbol Gives Rise to Thought," *The Symbolism of Evil*, trans. Emerson Buchanan (Boston: Beacon Press, 1969), 347-357.

[16] Dr Bill Bartholome wrote this when he was dying of oesophageal cancer. For this, see W. Bartholome, "Living in the light of death," *Bulletin of the University of Kansas Medical Center* 45, no. 2 (1995): 52.

[17] Michael Barbato, personal communication, 24 September 2012.

[18] Bartholome, 52.

All on-line resources accessed 1 October 2014.

Kevin McGovern ✠

Caroline Chisholm Centre for Health Ethics

Suite 47, 141 Grey Street, East Melbourne Vic 3002

Tel (03) 9928 6681 Fax (03) 9928 6682 Email: ccche@svpm.org.au

www.chisholm.healthethics.com.au

Subscription fees: Single $30.00 + GST; Overseas [single] AUD $40.00

Director/Editor: *Rev. Kevin McGovern Dip Ap Sc (Optom) (QIT), STL (Weston Jesuit School of Theology)*

Research Officer: *Mrs. Kerri Anne Brussen B App Sci (RMIT), Grad Dip Health Ed (La Trobe), Dip of Theol (ACU)*

Sub-editor: *Ms. Sofia Mehreen MA Business (Prof. Accounting) (Victoria Uni) MA (English Literature) (Punjab University) BA (Mathematics and Economics) (Punjab University)*