

TRANSCRIPT

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

Subcommittee

Inquiry into end-of-life choices

Melbourne — 14 October 2015

Members

Mr Edward O’Donohue — Chair

Ms Margaret Fitzherbert

Ms Fiona Patten

Ms Nina Springle

Staff

Secretary: Ms Lilian Topic

Witnesses

Ms Lesley Vick, President, and

Dr Rodney Syme, Vice-President, Dying with Dignity Victoria.

The CHAIR — I declare open the Legislative Council Legal and Social Issues Committee public hearing in relation to end-of-life choices. I welcome the president of Dying with Dignity Victoria, Ms Lesley Vick, and the vice-president, Dr Rodney Syme. Thank you both for being here with us this afternoon. Before I invite you to make some opening remarks, I will caution that all evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Therefore you are protected against any actions for what you say here today, but any comments made outside the hearing are not afforded such privilege. Today's evidence is being recorded. You will be provided with proof versions of the transcript within the next week. The transcripts will ultimately be made public and posted on the committee's website. We have allowed 45 minutes for our session today. I invite you to make some introductory remarks and thereafter the committee will have questions.

Ms VICK — Thank you very much for the opportunity to appear before the committee on this important issue. I just wanted to make a few brief comments to give a broad overview of our submission, which you have already received, and it is very extensive. To reinforce our comprehensive approach to end-of-life choices, Dr Syme, who I am sure you are aware has extensive medical experience in this area, will be commenting on specific aspects of the submission.

As a law reform and education organisation, Dying with Dignity Victoria is in favour of legislative change to give effect to freedom of choice to enable competent adults with a terminal illness or intolerable, unrelievable suffering to die with dignity. This includes receiving assistance from a doctor so that sufferers, as I have defined them, can choose the timing of their death in circumstances acceptable to them. Dying with Dignity Victoria believes that no-one should be compelled to either participate or not participate in the assisted death of a sufferer and that appropriate safeguards, as recommended in our submission at item 2.8, should be put in place. Specifically we do not support assisted death for individuals who are incapable of rationally and persistently requesting assistance, nor do we support publicly available so-called peaceful pills or a do-it-yourself approach to end-of-life decision-making.

We have assembled, in our submission, extensive medical, legal, public opinion and ethical information in support of our preferred legislative outcome that I have just outlined. We also, in the submission, address issues raised by opponents of voluntary euthanasia, or voluntary assisted dying — the various expressions that are used.

From a medical point of view, the need for improvement in the scope and practice of palliative care for patients who die in extreme and unrelievable pain is discussed and, as you would be aware, is supported by many of the personal stories presented to this inquiry already. From a legal perspective, current Victorian laws are unclear, ambiguous, unenforceable and indeed largely unenforced. Furthermore, those laws are lagging well behind legal developments overseas and over time. The submission details these developments. This committee in fact is very fortunate in that it can draw on extensive overseas data from now well-established voluntary assisted dying regimes.

From a public opinion point of view, it is overwhelmingly in favour of an assisted dying option. The detailed data we have included in our submission demonstrate that there is majority support across all electorates and districts and across demographic groupings, including religion, age, education, gender and income.

Opponents of voluntary assisted dying express concern, if we were to legislate for an assisted dying option, about damage to the doctor-patient relationship. Those claims were also raised in relation to the Medical Treatment Act, which was passed in 1988, and they have not been borne out in the 27 years of operation of that legislation. Nor has the claim that the Medical Treatment Act would result in reduced palliative care funding — in fact the opposite is true — and the claim about coercion being exercised by avaricious relatives. As far as the latter is concerned — coercion on people — Dying with Dignity Victoria would argue that the best protection against abuse is a system that is transparent and monitored.

Other claims by opponents, such as sufferers changing their minds, slippery slope arguments and religious concerns, are covered by our recommended safeguards that I mentioned previously. On the issue of religion specifically, we would note that not only do most people of faith support voluntary assisted dying, even if their church leaders do not, but in a secular society we do not consider that a faith-based opinion should determine legislative outcomes.

In short, we think that the substantive evidence we have presented supports the establishment of a controlled process of medically assisted dying and that this can be achieved with acceptable safeguards.

Dr SYME — A committee of the Victorian Parliament met in 1985 to discuss very similar issues. The findings of that 1985 parliamentary committee led to the Medical Treatment Act, which enshrines the principle of patient autonomy, the right to refuse any medical treatment and to appoint a medical enduring power of attorney to allow the perpetuation of autonomy to continue when one is incompetent. It also stated cogently that dying patients should receive maximum relief of pain and suffering.

Since 1985 and that inquiry, palliative care has blossomed and has introduced terminal sedation into its practice, using a syringe driver for the continuous delivery of analgesics and sedatives. In people suffering from what they call refractory symptoms, which others might call intolerable and unrelievable suffering, palliative care can provide continuous delivery of analgesics and sedatives by titration — that means the slow and incremental increase — without the provision of hydration, to slowly induce over some days a deep continuous sedation which can only result in death. In Victoria this is not a reportable death. There is no information as to how often it occurs, under what circumstances or as to whether informed consent was obtained. Moreover it is a process which remains entirely under the control of the doctor, who judges whether the symptoms are refractory, whether sedation should be provided and at what rate sedation will occur.

It is this palliative approach to refractory symptoms that I find unsatisfactory. It does not provide maximum relief of pain and suffering in a timely fashion. It does not respect patient autonomy. Dying persons should have control over the end of their lives, not their doctors. Previous Victorian governments have persistently stated that there is no need to change the law because palliative care is adequate. This mandates that Victorians must die according to the dictates of palliative care. This does not meet the wishes of many Victorians, and it is not the role of Parliament to dictate how we die.

Currently Victorians can effect their dying in three ways: refuse life-sustaining treatment, if they have such an option, and hope they will receive maximum relief of pain and suffering; by voluntarily refusing food and fluids, and hope their doctor will arrange good nursing care and some palliative drugs, and expect to die in 7 to 10 days; or receive slow, terminal sedation in palliative care, but hope they will receive more generous terminal sedation when they want it, and there is no legal impediment to offering this.

There should be a fourth way, one that I have witnessed many times. After careful assessment by their doctor and involvement with the family, the suffering person determines when the time is right and can then gather their family around them in their own home to say goodbye and, with their doctor present, if they wish, for comfort and support only, consume the medication. They will then go quickly to sleep with certainty, peace and dignity in about 3 minutes and die quietly in anything from 5 to 20 minutes.

Legislation to allow the provision of oral medication to hasten death for people with intolerable and unrelievable suffering is effective in palliating psychological and existential suffering, improving quality of life, preventing a hastened death in some circumstances and providing a dignified death under the control of that person, if necessary. The necessity for the delivery of a lethal injection is exceptional. It is essential to understand that such suffering is not confined to those with a terminal illness.

The CHAIR — Thank you both for those introductory remarks. I would just like to address the first question to Ms Vick. In relation to your comments that dying with dignity has support across the community — and I note that in your submission, in table 7 and on pages 51 and 52, you have given some detail about that on the basis of religious belief — can you give some details in relation to our culturally and linguistically diverse communities?

Ms VICK — I am sorry?

The CHAIR — Can you talk to how you perceive the support for dying with dignity from people of different ethnic backgrounds and people from different communities within Victoria?

Ms VICK — Different faiths and so on?

The CHAIR — More than just faiths, but different cultures and backgrounds.

Ms VICK — There are of course some cultural groups, as there are some faiths, that are not in favour of voluntary assisted dying. Nevertheless the opinion polling data shows pretty clearly that there is a majority across all the demographic groupings, including religion, as I mentioned.

What I want to reinforce from Dying with Dignity Victoria's point of view is, as I said in my remarks before, we feel very strongly about people not being compelled to participate or not participate in an assisted dying situation. Our safeguards, we believe, accommodate the beliefs of individuals. I would also reiterate the remark I made before — that in a secular society, whatever cultural, religious or ethnic views are held across the community, that should not, I believe, be the basis for a legislative outcome, as long as you protect the right of people who object not to be compelled but allow those who wish to do so. This applies to a range of things, of course; there are other aspects of medical attention where the same issues arise.

The CHAIR — If what you are proposing were adopted, would that extend to religious-based healthcare providers being exempt from any changes that you are proposing? Is that what you are suggesting?

Ms VICK — It is obviously an interesting question, because many healthcare providers do receive the Queen's shilling, as they used to say, the taxpayer funding. I have to say I am uncomfortable about the idea that people who receive taxpayer funding should be exempted from the application of the law, if we were to legislate for an assisted dying process. But at the individual level I think people's individual beliefs can be protected, as they are in the abortion law in Victoria, for example, where doctors have a right to refuse but they refer a patient on to somebody else. I think you can deal with those situations in those ways.

Ms SPRINGLE — I am curious to know — this may seem like an obvious question, but I just want to unpack it a little bit — what your definition of a terminal illness is.

Ms VICK — It is a medical issue, so Dr Syme can come in on that.

Dr SYME — 'A terminal illness' is a very vague term. I have criticism of the Oregon legislation, which uses terminal illness as an entry point for a request. It says a terminal illness is defined as someone who will die within six months. That quite frankly is ridiculous. I cannot make that determination. People in Oregon have had their medication provided and are still alive three years later. You can only as a doctor determine somebody's imminent death probably within two months of their dying.

The whole point about it is this: that suffering is not confined to people with a terminal illness. Suffering is much broader than that. The reasons why people request assistance is because they have suffering that is intolerable to them and unrelievable in any way. That to me is the logical entry point to legislation. If you look at the Belgian and Netherlands legislation, their entry point is unbearable and hopeless suffering, which essentially is the same as intolerable and unrelievable — we just use different words for it. I would make this point: that a person who has intolerable, unrelievable suffering but has not got a clear point at which they will die may live for some years with that suffering. The total quantum of their suffering is vastly greater than a person who may die in a couple of weeks.

I think it is very important this committee understands that suffering is the critical point of entry, that patients are the people who can measure their suffering. I as a doctor cannot measure your pain. I cannot measure your breathlessness. I cannot measure your psychological suffering or your existential suffering or the suffering you have from profound weakness, loss of appetite. These are things which only you can measure and value. A stoical person may put up with something which another person will not. It is the individual who makes effectively the judgement about intolerable suffering. The doctor simply has to approach that in terms of proportionality — has this person got a physical illness and circumstances that would make it reasonable that they would have intolerable suffering — and respect the judgement of their patient.

Ms SPRINGLE — In that case the decision-making really is down to the individual.

Dr SYME — Yes.

Ms VICK — Personal autonomy is at the heart of the approach.

Ms SPRINGLE — In your view is a time line relational to that?

Dr SYME — There obviously is, but there can be people who may have intolerable suffering, as I said, which may go on for years. Those people need to be treated with very, very great care, because they may have an associated depressive illness that needs to be sought and treated if it is there. Mind you, in many of those cases — people particularly who have chronic pain which is unrelievable — it is not surprising that they have a depressive illness, and it is extremely difficult to treat it. But that is an occasion where in my view — and I have dealt with such patients — you need to take a long and extended view of the process, try and support them as far as you can go. But ultimately some of these people — people with chronic arthritis, for example, chronic rheumatoid arthritis, particularly chronic organ failure, chronic cardiac failure, respiratory failure, struggling to breathe — may go on for months and years. This is suffering of a great degree, and it should not be denied, because you cannot say, ‘Well, they are going to die in two months’. I do not think you could deny the suffering that they have. It is not based on time, it is not based on illness.

Ms FITZHERBERT — I have read your submission. We have had a lot of submissions, so I just want to make sure that I am understanding clearly what your recommendations are. I have opened up the submission to pages 9 and 10, and I want to just dig into it a little bit. When you say you do not want to see a situation where someone seeks death and obtains it when they have lost mental competence, does that mean that what you envisage is a system where people can request a procedure pretty much immediately before it happens? Or can you anticipate circumstances and say, ‘If I am unconscious and in these circumstances, at that stage I would like to be assisted in dying’?

Dr SYME — No. There has to be an explicit request from a person who is rational and competent at the time.

Ms VICK — Crucial.

Dr SYME — Absolutely. For people to make decisions in my view even on the basis of an advance directive for explicit ending of life is going too far.

Ms VICK — We quite explicitly there in dot point 1 under 2.7 exclude adults who have lost mental competence, yes.

Ms FITZHERBERT — That was the bit I just wanted to explore with you. Also on the following page, on page 10, under your safeguards, the second-last dot point is suggesting that all deaths under VAD legislation should be recorded as due to the disease that was underlying the request. Why is that, if the death is actually caused by something else?

Dr SYME — I can refer to my analogy with terminal sedation. It has been considered apparently by law and by the coroner as being a natural death, and yet the person has died of what is actually an anaesthetic process. You see, it is rather in some ways insulting to a person who is thinking rationally and clearly, who is suffering intolerably and says, ‘I don’t want to die, I want to be relieved of my suffering’, and so they take medication which ensures that that happens. They are actually dying of an illness, a disease. It is rather insulting in my view to categorise them as having died by active suicide.

This is quite different from what the community generally accepts as suicidal behaviour, which is that of a person who is irrational, mentally disturbed, not giving due consideration to the circumstances, believing that there is no other option that they have, whereas in fact if they get good medical care, they can come out the other side and live for another 50 years. We are talking about people who are not going to live for another 50 years. They are dying, and they are taking a rational approach to the suffering that they have. There are actually dying of their heart failure or their cancer, and that should be the thing that is recorded. It is insulting to say that they have died by overdose. It should be recorded at a lower level.

Ms VICK — That they were given the assistance, yes.

Dr SYME — At a lower level, but not as the primary reason for their death.

Ms PATTEN — Thank you. With your recommendations of how you would see the legislative approach where you take the two doctors et cetera, looking at the other countries, Netherlands, Belgium, or the varying versions of the Oregon model, which is yours most similar to? Could we compare it to another country’s model?

Ms VICK — None of them are identical to what we are recommending, obviously. For instance, we support self-administration rather than a lethal injection.

Ms PATTEN — You support both, don't you?

Ms VICK — No, we are in favour of self-administration.

Ms PATTEN — Unless the patient cannot self-administer?

Dr SYME — Yes.

Ms VICK — There is an option, yes.

Dr SYME — Can I add in there that from my experience — and I think this is very accurate — the vast majority of people who make requests for assistance to die are capable of doing it themselves. It is only a person who cannot ingest, cannot swallow or cannot absorb oral medication who needs the assistance of a lethal injection, or somebody who is so totally paralysed that they simply cannot do anything to help themselves. These are exceptional circumstances. The great point that I would make is this: as far as a doctor is concerned, you want to be relieved of your suffering. Whose responsibility is that ultimately? I would say it is yours, as a doctor. If you are not prepared to take that responsibility, how could you ask me to do it? If it is your responsibility and you have to take the action, that is a fundamentally powerful control over the process; no-one's life will be ended by a lethal injection of a doctor who does not consult with the patient. You have control. In Oregon, for example, 30 per cent of people do not use the medication. What it has done is provide them with control. If you have control, it gives profound peace of mind.

If I may, I will take this opportunity to read a letter to you, which serendipitously I received in the post this morning at 11 o'clock. I think it is a very important letter. This is from the mother of a young man, 53, who is dying of lung cancer. He has probably got about two months to live, and I saw him last Thursday. She wrote to me and said:

I appreciate your graciousness in taking time to talk to my son ... in such candid terms on Thursday last.

I write to tell you of the effect your discussion of the options for him had, not merely on his demeanour, as you immediately recognised and commented upon, but on his entire physical being. For the very next day he got out of bed, showered, dressed and drove himself to Cheltenham to visit a friend to discuss music, guitars and the exigencies of life, returning mid-afternoon to rest and have other close friends come to visit him in the evening. All this resulted from his following your regime for medication taking, sleeping for at least five hours and feeling liberated to live and die in his own way and time. He was unable to achieve this before talking with you — so the effect has been remarkable.

I did not provide him with any medication. I talked to him and opened the gate for a conversation to take place. When he came to see me he was a broken man. He came through the door, he talked monosyllabically, his head was down and his brow was furrowed. As we talked and opened and discussed his circumstances, you could see him rising up in the sofa. His smile came over his face, his frown went away and he began to engage in conversation. This is the power of good communication and giving a person — not a patient, a person — control over the end of their life. His psychological and existential suffering has been eliminated, and he is now living a better quality of life. He may not live any longer, but he may because he has now got this tremendous anxiety and fear out of his life. That is what can happen if you have the ability through law. The reason it had not happened with the doctors he had previously seen was because the law imposes a barrier to these sort of discussions.

Ms VICK — I would just add the depressing observation that if people are fearful that they are not going to exercise the sort of control we are discussing, they would certainly perhaps take precipitate action, but violent unpleasant action — jumping in front of a train. These are well-documented instances, and that is an argument on the other side of the coin I think.

Ms PATTEN — We received some compelling evidence from the Coroners Court in regard to that, and it was quite extraordinary.

Ms VICK — Yes. We saw the evidence from them the other day.

Ms PATTEN — To clarify this, to me it looks quite similar to the Oregon model, with the exception that we are adding intolerable suffering to it.

Ms VICK — I think it is probably the closest; not identical, but the closest.

Dr SYME — Very similar.

Ms PATTEN — They were sort of broadening it. In Oregon is it two doctors as well?

Ms VICK — Yes. And of course you have got the benefit of the fact that they keep extensive data. It has been in operation since 1998, which would obviously be a valuable resource for the committee, and I am sure you will be looking at that.

Ms PATTEN — Yes, we are.

The CHAIR — Dr Syme, you spoke before about physical illness. Whilst it is covered in your submission, for the sake of the transcript and the record, can you talk to mental suffering? We have heard from other witnesses previously that mental suffering should be part of the equation, part of what is considered. Can you talk from your position about mental suffering versus physical suffering?

Dr SYME — Mental suffering can exist in its own right as a single entity — people who have chronic depression or chronic schizophrenia. A famous Australian psychiatrist, John Cade — you may have heard of him; he was the person who discovered lithium for chronic manic depression — said that depression is one of the most painful illnesses known to man, equal to that of any suffering from cancer. That in its own right — I do believe in some circumstances — can be an indication for assistance, but that needs to be very carefully assessed by experts in that area, psychiatrists. I have had people come to me with a psychiatric illness, and I will not give them advice, because I do not have expertise in that area. That is an expert area.

In the main, however, anybody who is dying of a physical illness has got an enormous psychological impact. Many people do not recognise this, but it is absolutely critical. If you are dying and you are dying badly, you are suffering from a great deal of anxiety, terror and fear. You have no control over what is happening, and other people are making decisions about it. The psychological impact of that is disastrous. We feel pain in the mind. The state of the mind — its state of anxiety and distress — aggravates all of the physical symptoms that we might otherwise feel. If you can relieve that psychological suffering, you can often relieve a lot of the physical suffering as well, as indicated by that letter. Psychological suffering is an essential component of almost everybody who is suffering from severe physical illness. The relief of that has a profound value, as I have indicated.

What we also say in the submission is the effect of existential suffering. I mention this reluctantly, because when we introduced a bill through Colleen Hartland in 2008 into the Parliament, many people threw up their hands and said, ‘What the hell is this existential suffering that is talked about in this bill?’. It is very simple. Existential derives from the word ‘existence’. The things that make us human and are real and have value in our lives are what constitute existential suffering when they are threatened — when you can no longer have any enjoyment in your life, anhedonia, when you can no longer create and do anything effective for the community, when you feel that you are a burden to others around you, even if they accept the burden. Being a burden to your family is not something that any of us particularly wants to do.

These are the existential aspects of suffering which are equally important to people depending on their values. They are again one of the unrecognised phenomena that accompany almost everybody who is going towards the end of your life. If you talk to them openly with good communication, you find out that these are things that are troubling them. All the research in all the countries where they have passed legislation finds that psychological and existential issues are two of the very important things which will make people find that their life is intolerable. Does that make sense?

The CHAIR — It makes sense. To summarise, whilst I accept your proposition that you are not a psychiatrist or an expert in depression or those sorts of matters — but to be clear about what you are advocating for — you are not suggesting that people who are suffering depression or severe mental suffering be eligible for any sort of change that you are proposing.

Dr SYME — Frankly that is something for the committee and the Parliament to decide.

Ms VICK — Yes. It is not what we are advocating for, but obviously I imagine it has come up in other sessions and in other submissions.

The CHAIR — It has, and that is why I ask it.

Ms VICK — We are adopting the clearly enunciated view that we have. It seems to us an appropriate legislative reform in this state, and we hope the committee considers it sympathetically. But no, we are not advocating for things beyond that, to really answer your question.

The CHAIR — Thank you.

Ms PATTEN — This morning we heard from Alzheimer's Australia and Council on the Ageing, and looking at the numbers of Australians who will be living with dementia is quite a frightening statistic, when we are looking at over a million people in 2050 who will be living with dementia. How are we going to enable them to die with dignity if we are saying that you have to be completely competent to make the request to your physicians?

Ms VICK — In distinguishing our position, we are only advocating for mentally competent people requesting this, and I do not need to go through all the details that we have in our thing. But I do think the community is going to have to have a debate about what you have raised. Sometimes people talk about rational suicide. There is a great need for these things to be debated in the community, and obviously this committee will probably address some of them. But are you asking whether Dying with Dignity Victoria advocate that?

Ms PATTEN — Yes.

Ms VICK — We certainly recognise that these issues, such as those mentioned by Dr Syme before and what you have raised, are going to need to be debated.

Ms PATTEN — I know, because you are quite emphatic about advance care directives not including a proactive dying with dignity option, and I am concerned about people with a diagnosis of dementia who, as we heard this morning, had seen their parents or their family members suffer.

Ms VICK — Yes, and decline over a long period of time.

Ms PATTEN — That is right. So they have immediately said, 'I do not want to die that way'.

Dr SYME — I have a deep experience of Alzheimer's disease and dementia. There is no doubt that it is probably one of the most feared conditions that people have, and I personally would regard it as the worst illness that I could possibly confront — worse than cancer by miles. The thing we need to recognise is that people in the early stages of dementia do still retain competence. Of course it is lost progressively. I have indicated in my submission that I am a humanist and I do not have any dogmatic religious beliefs, but I do believe in the Golden Rule: do unto others as you would have them done unto you. I believe that if I were confronted with a diagnosis of early dementia, I would seriously think about how far I would go with that journey — seriously think about that.

The other way in which this matter can be dealt with, and I think should be dealt with at the present time, is by the promotion of advance healthcare directives for people who are either concerned about dementia or diagnosed with early dementia, which would allow them to say, 'If in the advanced stages of dementia when I am incompetent, if I have any life-threatening illness, I do not want any life-prolonging treatment, including' — and this may seem a little shocking to you — 'artificial feeding and assisted spoon feeding'. Because that is the thing which prolongs the lives of many people in vegetative state in the advanced stages of dementia. It is pointless and futile. It is ineffective, and all it does is prolong suffering. Yet it is something I think most people in the community really have never thought about.

Ms VICK — I would also add to that from a legal perspective, which is my background, that advance care directives currently allow you to in advance refuse certain things, so it is a logical extension really of what is already covered by advance care. I would just say in passing that Dying with Dignity Victoria is very pleased to see the government have said they are going to give legislative standing to advance care directives. That is something we have been agitating for for some time, so that will be a pleasing development. Really this is just a logical extension of what the advance care directives are about: about declining certain treatments in advance —

not about demanding that you be given Nembutal or whatever, but declining certain treatment that already exists. I would not see any legal argument really against moving in that direction.

Ms PATTEN — Refusal of treatment does not concern me, and I do not think with dementia an advance care directive would be quite appropriate to that. May I be one of those million people in 2050 who has dementia and my only option will be to refuse treatment, rather than take a more proactive stance.

Dr SYME — I notice that you are interviewing Dr Charlie Corke tomorrow about advance care planning.

Ms PATTEN — We are going to do an advance care plan.

Dr SYME — If I could just make one comment about that — that is, advance care planning is often based around documentation which the individual person has to fill in in their own words. I just issue a word of caution that that can lead to a circumstance where the advance care plan is providing an invitation or a request in relation to future treatment. In my view for a document to be of value it needs to be a directive. It needs to state exactly what that person wants — not an invitation to the doctor to say —

Ms VICK — Yes or no.

Dr SYME — ‘Well, these are my vague views; you make the decision.’

Ms VICK — This is what I want.

Dr SYME — I want to be able to make the decision, make it clearly as a fully informed rational person. I am fully in favour of advance care planning as a general thing, getting people to communicate, but ultimately the document that comes out of it, in my view, has to be a directive.

Ms PATTEN — I think it had such an impact this morning. So dementia is a terminal illness?

Dr SYME — Yes, it is — absolutely.

Ms VICK — Indeed.

Ms PATTEN — So at that diagnosis I could go and see my doctors and say, ‘I have been diagnosed with a terminal illness and I would like a prescription’, and at that point I suppose I am not sure that we need be competent.

Dr SYME — You would have to judge the competence. It is possible.

Ms VICK — Assuming the person is competent — yes

Ms PATTEN — So you are assuming you are competent at that point?

Ms VICK — Yes. We of course are generally, are not we all, talking about people who have gone well beyond that, and even if they got the prescription previously they are at that point, who knows what they would be able to do? That is the awful bit, is it not? That is the awful bit that we all recognise is going to be a growing problem, quite obviously.

Dr SYME — I would not anticipate that this committee will make direct recommendations about dementia, but I am glad you raised it because to me it is part of a debate which needs to go on —

Ms VICK — We need to debate it.

Dr SYME — over the next 10 or 15 years. It has taken 30 to 40 years in the Netherlands — where they have been discussing these things in a mature way for 30 or 40 years — to finally start discussing this very issue. So it is something that is developed over time. It is an incredibly difficult issue.

Ms SPRINGLE — Just on that, talking about a public discourse and a conversation, what comes first: the conversation or the legislation? Or do they happen in tandem in your view?

Dr SYME — There has been a discussion going on in this area at least since 1996 when Marshall Perron introduced a bill — that is, 20 years ago. Ten years before that you had the parliamentary committee inquiry. People say, ‘We need to have a debate about it’. For God’s sake, we have been having a debate for 30 years. A lot of people have not been listening. They do not want to listen or they have fixed views.

Ms VICK — As you would know too, numerous private members’ bills have been put up in legislatures around Australia. We have had 18, I think, on my last count, and apart from Marshall Perron’s, which of course was overturned by the federal Parliament, none of the others were successful. So that debate — I agree with Dr Syme — has absolutely been had. The dementia debate — we need to get that underway, yes,

Ms PATTEN — I have just one further question. The police came in the other week. It was very enlightening evidence that they gave, and they were very frank. They did speak about assisted suicide and prosecutions on it. I understand that all they were saying was they really had not had any with doctors despite there being some very public statements made by you, doctor. You have been very public about the assistance you have provided. Why do the police not take action?

Ms VICK — They go and interview him.

Ms PATTEN — Yes, I know. They pop over, say hello.

Ms VICK — Have a chat. They probably all leave feeling better.

Dr SYME — I think it is an embarrassing question for the police and an embarrassing question for the Director of Public Prosecutions. I think it is quite clear to me. I have been interviewed nine times by the police about various matters. They show, I can only say, a reluctance to pursue the matters with any sort of vigour. I think that the commissioner who was here said he had only ever once had to raise one prosecution. Do you think for one moment that over the last 50 years doctors have not been helping people to die? Of course they have. But these matters are not pursued with any vigour whatsoever, unless somebody makes a complaint, and who is going to make a complaint about their loved one dying in a peaceful manner? They just do not do it, and doctors do not talk about it, except perhaps me.

Ms PATTEN — Yes!

Dr SYME — I have had unique experience in this matter, and that is why I am prepared to talk to you about it, because it is important, I think, that as a committee you understand what actually goes on. Doctors do ease death; of course they do. Our duty is to relieve suffering. It is a necessity on occasions. Sometimes suffering will only end with death, and I as a doctor have a responsibility to see that that happens, not like palliative care, which says, ‘No, no, we don’t hasten death, we’re just relieving suffering’. They hasten death as much as anybody does. But for moral reasons, in my opinion, they simply do not acknowledge it. The police are in a hard place.

Ms VICK — Yes. It is not their fault.

Dr SYME — They do not want to stir the pot, because if the police prosecuted a doctor, like me for example, think of the message that would send to the rest of the medical community, ‘Hey, do not go near this, or you’re in grievous trouble’. Doctors skate under the surface because of the double effect. I can give whatever treatment I want to a patient who is suffering, provided that I can argue and maintain that my intention is to relieve suffering, and that of course is not difficult to do. Who can disprove my intention?

Ms VICK — We make this point in the legal section of the submission, as you would realise. I would reiterate the point I made earlier: if there is concern about abuse, it is surely better to have an open and transparent system than the current ambiguity, lack of clarity, laws that are not quite enforced and doctors’ mindsets that you cannot determine. That is not good from a legal point of view and it is certainly not good from a medical practice point of view.

The CHAIR — We are getting to the end of our time with you.

Dr SYME — Just before we finish, might I present to each member of the committee a copy of my book, *A Good Death — An argument for voluntary euthanasia?* It contains the story of my journey in this matter. It

gives a lot of examples of assisted dying and an analysis of the arguments which support that. I think you will find it interesting, and I hope informative.

The CHAIR — Thank you, Dr Syme, we much appreciate it. Just before we close, I would like to say there has been some discussion about the evidence of the police, and I encourage people who are interested to refer to the transcript of what the police said, because they said in very clear terms that they apply the law. I think it is important to make that point.

Dr Syme and Ms Vick, thank you very much for being with us today and for your submission. As I said at the outset, you will be provided with a draft version of the transcript in the next week or so.

Ms VICK — Thank you very much for the opportunity.

Dr SYME — Thank you.

Witnesses withdrew.