

TRANSCRIPT

STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

Inquiry into end-of-life choices

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

The CHAIR — I welcome to the committee this afternoon Dr Michelle Gold, the director of palliative care at Alfred Health and the member of the Australasian Chapter of Palliative Medicine of the Royal Australasian College of Physicians. Thank you very much, Dr Gold, for making yourself available this afternoon. We have allowed an hour for your presentation. I ask you to make a short opening statement, and thereafter the committee will have questions.

I should caution before we start that all evidence at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Therefore you are protected against any action for what you say here today, but any comments made outside the hearing are not afforded such privilege. Today's evidence is being recorded. You will be provided with a proof version of the transcript within the next week. Transcripts are ultimately made public and placed on the committee's website.

Dr GOLD — Thank you very much for inviting me to speak here today. I think this is a really important inquiry. As you have just heard, I am director of palliative care at the Alfred hospital, which is a very acute medicine kind of place and a very interesting place to practice palliative care. For the last three years, I have also had a small part-time role with the Victorian paediatric palliative care service.

Clearly the subject of this inquiry is something that I have spent many, many hours thinking about in all its various aspects. I could probably talk to you all day or all week on the subject, but maybe the most useful thing might be if I share some of my clinical perspectives and expertise with you. I will try to keep this really brief so that you can ask me more questions.

By way of introducing why I am doing what I am doing, I first started thinking about palliative care as a career as a very junior doctor working in intensive care. It was in the early days of bone marrow transplantation, and we were looking after a young woman whose transplant had clearly not gone very well at all. Despite the incredible efforts of our ICU team, it was clear that she was going to die. Her family were there; they were in intensive care, sitting around the edges of the room, grief-stricken and silent.

The ward clerk, who was wiser than many of the other people in the unit, declared that what we really needed was pastoral care. It was after hours on a weekend, but she proceeded to ring around until she found someone to come to the hospital. This chap was amazing. In a very short space of time, the whole atmosphere in the room had changed. The family was sitting close by the bed, stroking her head, sharing stories, talking, even laughing a little bit, and it really changed the way that I conceived of dying, how that would happen in an acute hospital and how death could be. She was very peaceful when she died. That was one of the events that set me on my course and pathway in a role that I love and I find incredibly fulfilling, but more importantly it leaves me weekly in awe of what people can achieve and do.

There has obviously been a lot of talk about end-of-life care and how people die, and I am concerned that the community narrative on end-of-life care is very skewed. It seems that there is an overly bleak picture of death and dying that has come into the public mind and context that death is always frightening. I think that is quite misleading. It seems to be something that by definition must be painful, undignified, ghastly, and if that is your impression, then of course it is no surprise that people want to avoid death at all costs — which I can assure you is not possible — or to exert some sort of control over it.

My experience as a palliative care professional is really that death and in fact the whole end-of-life process can be something quite different. Even when a death is not wished for, which is the vast majority of the time, it can be a peaceful and meaningful process, and those last phases of life can contain many opportunities for important interactions, fulfilment of wishes and really crucial goodbyes. Many precious memories are created when people have an opportunity to confront imminent death with support, information and expert care.

I have some strong concerns about the voices that we hear from people who are lobbying for euthanasia. I have spoken at different public forums and with people who are members of Dying with Dignity or supporters of euthanasia. I am struck quite deeply by the scars that these people seem to bear from their past experiences with death. They relate stories that cause me a lot of pain to listen to, and I can only imagine how much more painful the experience was for them. I shudder sometimes when I hear what their relatives have been through, or the picture these people paint of what their relatives have been through, and without being full of myself I truly believe that many of them would not have had that same experience had I or one of my colleagues been able to provide care for them at that time.

But clearly it is not that simple, and I think memories can sometimes be unreliable, and who am I to say that what I think the patient is experiencing is the same for the patient. They most often cannot tell me. Perhaps what I see as being a reasonable, peaceful death might not be experienced that way by someone who is losing the person they love most in this world.

We can provide really excellent or very good levels of comfort for the majority of patients we care for. I could not honestly pretend to say that we are successful 100 per cent of the time; I acknowledge that. We cannot do a perfect job at this stage, but I think, nonetheless, a strong palliative care network to provide care for the most vulnerable people in our community is a really critical foundation for excellence in end-of-life care.

If we are not getting it right all the time, what are the problems? In a small number of patients, they just have difficult refractory symptoms that despite our best ministrations are going to be hard, but I believe that is a very small percentage of patients. More often — and I think for me more disturbingly — many patients suffer because they are not referred to palliative care early enough, or we are not notified that their symptoms are not responding to treatment. I get very frustrated when I come in in the morning to find that someone has had a tough night, but no-one called me at 2 o'clock. I will not have any trouble going back to sleep, but everyone who is standing there watching that patient is going through a really horrible experience.

I think sometimes there has been so much effort and energy invested in really complex therapies to treat failing organs and life-threatening diseases that the teams can sometimes fail to see the patient at the end of the tubes who simply cannot struggle on any further. It is very hard to be the first one in that circumstance to call time and say, 'Maybe it's time to give up on the hope of cure and survival; maybe it's time to look at something else'. So there are many things that I think can be improved. I am happy to talk a bit later — whether you have some questions. But I think the palliative care sector could be strengthened and expanded in some ways to have a greater presence in areas of medicine outside oncology. We do really well with a lot of our oncology groups but not so well in the non-malignant sector. I think a strong representation at acute hospitals is really important — obviously that is where I sit, so I might be biased — but we also need to fill some gaps in the community.

Education in palliative care is a major concern that I have. Without mandated curriculum content we seem to be releasing medical and nursing graduates into the system who may have only a few days training or exposure to the principles of palliative care throughout a four or five-year course. Trainees in all areas of specialty medicine — and I am including general practice in that — need to have skills in the area. All physicians and doctors should have much greater requirements for excellent communication skills and training in that area.

There are some really hard conversations to be had around end-of-life care. We were dealing with a delightful young man this week who has had a lifelong illness but obviously things have deteriorated in the last little while. His parents have been there caring. He had a condition that is transmitted through the mother's genes. She was there and was completely devastated with the sense of guilt, which is understandable even though she could do nothing about it. Talking to this young man and his family about what was going to happen in the next few days was an incredibly hard conversation to have, but they are much harder conversations if you do not have the language to address these issues, or indeed have the confidence that you can do it without further traumatising the family.

I think community understanding of palliative care certainly needs to be improved. It is changing, but at a very glacial pace. I see many families who do not want to meet me. I am really not that scary, but they want to pursue every last second of existence on this planet, and they are incorrectly worried that if they agree to meet with me or with my team that that would be perhaps seen as an indication that they might be willing to let go and to give up.

I can only imagine how much more difficult that would be if there was the feeling that we might by some means be providing euthanasia or ending life before people are ready for that. So I do worry about that. I worry about how that is going in the countries and the jurisdictions that have legalised euthanasia. I certainly feel very strongly that that is not what I signed up for and what many doctors would say they probably have not signed up for.

I think I will probably stop talking there, because you have heard enough from me for the minute. But, as I say, I am more than happy to field questions on any areas.

The CHAIR — Dr Gold, thank you very much for your opening comments. It is great to have your perspective as a practitioner. In that vein, can I just ask you to perhaps expand further on your comments about education, because we have heard from others today about the need for further education both in the broader community but also for health care professionals. I would be interested in your thoughts, particularly with healthcare professionals.

Dr GOLD — I have no doubt that there could be a lot more done to improve education of healthcare professionals in all fields. It really needs to start from the schools — the undergraduate schools — the medical schools and the nursing schools. But then it probably needs some reinforcement and ongoing education as people go through their specialty training thereafter. The communications skills training is probably something that needs to be ongoing. I do not think it is something that you can just do once and then you are good at it. It does not really work that way. We can always learn more. You fall back into old habits. You are busy. You have a lot of other things to do. It really helps.

I go back and do different courses and different things, and every time I do I learn something new and hope that I am doing it a little bit better. There are a number of areas that I think we could really enhance. As I understand it, there is no mandated curriculum or minimum curriculum. We know that everybody is going to die, and yet there is far greater training in obstetrics and gynaecology than there is in palliative care. Most practitioners will not really have anything to do with a delivery once they leave medical school, so the balance is wrong.

The textbooks, when you look at them, tell you how to make a diagnosis, what the symptoms are, how to start your treatments — they might give you two or three lines of treatments. But, other than a very few, they do not mention palliative care or what role palliative care might have, so there is a problem there from the get-go.

Mr O'DONOHUE — You referred to gaps in community palliative care, so can you perhaps identify from your perspective what they are and how we can do things differently?

Dr GOLD — I am not sure I can tell you how to fix it all, and I heard the team here speaking before. Certainly we are pretty fortunate in that most of the time we are able to refer people to the community services, and they are picked up reasonably quickly, but there have been instances this year where some of the services have had quite significant gaps for people who are deemed perhaps not acutely in need of the service. They might have to wait several weeks. Now, we have got ways we can put stopgap measures in place, but in an ideal world you would not have those gaps at all.

I think more importantly we are starting to get more referrals from the non-malignant sector and are seeing people with chronic diseases — respiratory diseases or cardiac diseases — and they tend to have a much longer period of being quite frail or needing a lot of care and a lot of symptoms support. That is going to overwhelm, I imagine, the community teams if we are putting a lot more people onto those programs who are going to be there for longer periods of time compared to the oncology population, which tends to have a relatively short trajectory. I think a lot of the services have been set up with those kinds of figures in mind — so strengthening that in a numbers sense, but also in an education sense for the palliative care sector. I think we have a lot of areas we could improve on in how we provide palliative care for people with non-malignant diseases. There is little bit of work going on around that in the college of physicians in training of the doctors, but it is just starting, so there is going to be quite a lead time before those people are out and practising in the community.

Mr MULINO — Thanks very much, Dr Gold, for your testimony. I found your story compelling as to the experience you had and what made you want to practise in this area, and it did strike me that it is an area where it is probably quite easy for professionals to focus too much on the clinical and not enough on the human side of things. That is a very interesting perspective.

Having said that, I want to ask you a question on the clinical side. Is palliative care an area of medicine where advances are being made in terms of the range of treatment options available to doctors in terms of what they can do to ease pain or to provide other sorts of care to patients?

Dr GOLD — Absolutely, and again I could talk to you for a week or so on this. There are always new medications available in that sense. We are having increasingly fruitful interactions with some of our interventional colleagues to provide pain relief with various procedures and interventions that are sometimes much better directed than the medications are and hopefully have fewer side effects. It is terrific that there are new techniques — new ways of delivering some of the old medication. Things are changing all the time in that

regard. I am certainly seeing a group of patients — and I know I work in a slightly rarefied atmosphere — where in some ways their palliative care could almost be difficult to do outside of an acute hospital. There having quite intensive forms of support, but that might be the best way to keep symptoms under control.

As new techniques, new drugs and new procedures are becoming more commonplace in treating patients at earlier stages of the diseases, some of those filter through. We have had people on infusion pumps of inotropes for cardiac support or on very highly specific drugs to improve their lung function. We have done a lot of work getting those people to hospices. They have got symptoms that can otherwise be beautifully managed by the hospice staff but there are infusion pumps and different things that are or have not been part of the training in palliative care. That requires the acute sector working quite closely with the hospices to make sure that that transfer is seamless — or as seamless as it can be. Does that answer that?

Mr MULINO — Yes, that is useful, thank you. Just a very brief follow-up: I am just wondering whether you notice improvements in the effectiveness of the non-clinical side of the pastoral care? Are we getting better at that? When I say ‘we’, I mean you!

Dr GOLD — Me, personally? Yes, much better! I think we are starting to make progress, but there is a bit of a groundswell of talking about death and dying, and any of those conversations can be useful. The work being done with advance care planning I think is starting to come through, and we are just hearing people who are having conversations. There is no doubt in my mind that when we are dealing with families who are facing the death of a loved one, if they have had some conversations — they do not have to have written anything down necessarily, but if they have had the conversations, it makes it a whole lot easier for them to feel that they are doing what that person would have wanted were they able to make the decisions themselves, and there is no doubt in my mind that the trauma for everybody is much, much less. I think that is starting to come through, and we are doing better in that context.

Ms PATTEN — It is great to have you here, and it is great to hear the improvements that we are having. I too have been really struck by some of the harrowing stories that I have heard of people with their friends and families and the pain and suffering that people are going through that may be needless. I have two questions. The first is: one of the professors we spoke to this morning talked about the defence for doctors when they increase pain relief that may hasten death and that possibly we need to change legislation to ensure that there is a good defence there for doctors. Is that something that concerns you or that you would be supportive of?

Dr GOLD — I would certainly be supportive of clarifying that legislation and having clinicians feel comfortable that they can do this, firstly, in good conscience but, secondly, without that risk perhaps down the track of being sued. If I can expand on that a little bit, in my personal practice I know that I titrate doses carefully. I have got a lot of experience in it, so I can do it quite comfortably and have a good feeling for what doses people might need. I do not always get it right the first second, but in a reasonably controlled environment I feel confident that I can get that right and that the vast majority of the time I am not even needing to think about that double-effect scenario or increasing doses in an unreasonable sense. But it is not uncommon for us to have a scenario on the ward where the nursing staff are very fearful that, if they give that injection and the patient dies at X point in time thereafter, there will be a repercussion for them.

Just this morning, that gentleman — that young man I was referring to — had some pain overnight, and we prescribed a medication for that. When I heard that he had died, I said, ‘I hope the nurses didn’t just give the drug and then think that they had caused his death’, because he was on a ward that did not commonly look after dying patients. So we do have that happening, and sometimes I am concerned that drugs will be withheld, or not given, or lower doses given because there is that fear. I am sure there are some doctors who would also be more concerned about increasing doses or using other medications because they are worried about that. I do not think it is a huge issue for most people, and certainly in palliative care I think we are quite comfortable with the ideas, but I do think it would be a terrific outcome to have that clarified and shored up.

Ms PATTEN — I will just ask for another clarification. You stated that in jurisdictions in countries where physician-assisted dying has been recognised in law you had some real concerns. I really appreciate the thought that that is part of it when people are going into palliative care, but could you just elaborate on what your concerns are?

Dr GOLD — If I can just come back with one story first, a gentleman I looked after many years ago, the first thing he said to me was, ‘I am a member of Exit Australia’. Terrific. That’s great! He had the means, and

when he wanted to go, he would go. We talked a little bit about when that would be and what might trigger that. Anyway, we passed about five or six of these milestones, and each time he would get to one he would say, ‘Well, when I get to that point, when I can’t look after this’ — he never used it, and I guess that is —

Ms PATTEN — And that is what we are hearing internationally, that it is rarely used.

Dr GOLD — So my concerns with some of these jurisdictions are that there seems to be this really significant increase in numbers accessing it. I have seen figures quoted at 15 per cent per year.

Ms PATTEN — We got 1 per cent today.

Dr GOLD — I cannot think which one it was — in the Netherlands somewhere — increasing up to 15 per cent per year, where it is being extended to children, to people with dementia, to non-voluntary, so that the person himself or herself is not the one requesting it but it is being requested on their behalf. I have difficulties with that. People talk about a slippery slope. It is not a term I particularly like, but it seems to me that perhaps there is some point at which you do open a wedge and more gets wedged through it.

Ms PATTEN — So upping the dosage is where you draw the line.

Dr GOLD — I make the distinction that I am doing it to control a symptom, and I will stop when the symptom is controlled. I do not keep going because the symptom is controlled and the patient is still breathing, and that is a problem: I stop. The symptom is controlled. I think there is a clear difference, and my intent is very, very clearly to relieve the symptoms.

Mr MELHEM — On the last point you made about when you stop treatment, would you stop treatment when there are reasonable grounds from your point of view medically that the medications or whatever the person is on are not working? Would you stop?

Dr GOLD — If a patient is having medication, whether antibiotics or other forms of support and treatment for a condition, I think there are times when we can say quite clearly, ‘This is no longer working’ or ‘It may be working to keep problem A sorted out, but there are now problems C, D, E, F and G that are not able to be managed’, or where there are competing things. Again it is not uncommon scenario that I am seeing where I work that people come in with multiple organ failures and if we dry them out to help the heart function, the kidneys go off and then we try to get them some more fluid to fix the kidneys and the heart. You get to a point where you just cannot find that balance. At that point, where the treatments themselves are more burdensome or more harmful than beneficial, I think the ethical thing to do is to rationalise those treatments and to focus on comfort measures.

Mr MELHEM — Following on from that, generally speaking are Victorians informed about the choices they have now and what is available? Can we do more to inform them about their choices?

Dr GOLD — I think there is a real range. Some people are incredibly well informed and, as I say, have had these wonderful conversations and come in with quite a clear idea of what they would like to have happen. I was looking after a wonderful lady today who is very clear that whatever she has got, she has lived her life and she wants us to look after her and care for her pains and other problems but not to prolong her life. That is great. Everyone respects that. But there are certainly other sectors of the population who I think just do not even understand that they can tell a doctor to stop or say, ‘No, I don’t want that treatment’. I suspect that is more common in some of our culturally and linguistically diverse communities, to use the phrase. They are not as well informed.

There are also just differences culturally in how willing people are to question doctors. In some cultures it is just not going to happen. The doctor is seen as this authority figure — that would be nice — and in other cultures, including my own, it is practically your duty to inquire and question and grill and make people explain exactly what it is they are doing and what they hope to achieve and get second and third and eighth opinions. There is a huge spectrum. I suspect we probably do need to focus on some of those groups.

Ms FITZHERBERT — I was going to ask exactly that question, but I have another, which is: one of the issues we discussed this morning with some other witnesses was the varied understanding of when someone is dying. I wonder if you could give us your perspective on how this works in practice in tandem with your role.

Do families in particular usually come to you with an understanding or do you have to give that information or how does it work?

Dr GOLD — If I can just focus it on the last days or hours of life, is that what you mean?

Ms FITZHERBERT — Yes.

Dr GOLD — We would divide it up in a variety of ways. But the last days or hours of life we see as a distinct phase, where you really do have a very clear approach as to what is important and we are aiming for comfort and so on and so forth.

Mrs PEULICH — So you are talking about the terminal restlessness stage?

Dr GOLD — The terminal phase, hopefully without the restlessness. One of the things we talk about is diagnosing dying, and we have put in quite a bit of work to try to help our clinicians diagnose dying because a lot of people are not that good at it. There are probably a whole number of reasons for that. They are not seeing it in medical school or nursing school. But we are also not seeing it as a community, as a whole culture, because 100 years ago people would die at home so you would see a grandparent be at home and die or it might be someone postpartum when deliveries were not so safe. Young people saw family members die as they were growing up. But the whole dying process has now become very institutionalised, whether it be in residential aged-care facilities or in acute hospitals. I think in general the community is not as familiar with people who are dying.

I remember when one of our counsellors first started working with us. He was very experienced; he had done a lot of work with people post-bereavement. But he had gone up to talk to a patient and came and said, 'Look, I went to try to see Mr So and So and couldn't really talk to him'. Something he said made me think, 'I'll just go and have a look'. I walked in there and it was very clear to me that this man was hours from death, but this counsellor of ours, who had a lot of experience caring for families who had lost a relative, just had not recognised that. I think it is a problem in the community and also within the healthcare staff sometimes. We have worked quite hard to try to make ourselves available to assist with that when there is any uncertainty, and then also to put some ideas and some coaching in place for teams to be able to look after people in those last hours and days of life.

I guess the other time premise sometimes to talk about is end of life in a sort of 12-month context, so people who are heading into that phase, and it is actually probably even more challenging to pick that time frame. But there are some clinical indicators that have been developed, particularly in the UK, that are well accepted and there is some research to back that up — the sorts of things that you might look for to say, 'I don't know exactly when this person going to die, but it would not be a surprise if they were to die within the next 12 months'. We actually talk about the surprise question. That is something that I think is also important — that we start educating our clinicians in all the different walks of medicine in that area.

Mrs PEULICH — Thank you, Dr Gold. Just as a prelude, my father was an oncology patient at your hospital where he was in receipt of palliative care.

Dr GOLD — I hope we did a good job.

Mrs PEULICH — It was some 20 years ago, and you would have been a school student no doubt. I have just two quick questions. When you were speaking about the expansion of palliative care, and I note there was a similar question asked, do you envisage that that will extend to perhaps noting your concerns about attributing wishes or decisions to those who are inarticulate for whatever reasons? Do you also believe that the expansion of palliative care will perhaps include experiential pain or mental health areas?

Dr GOLD — That would be really great. Again a lot of the time the distress that people exhibit and are experiencing may commonly have a physical element, but there are also commonly other elements to that distress and to that pain.

Mrs PEULICH — So would you say that the view that palliative care needs to expand to include mental health patients and those suffering from experiential pain is a more commonly held view by medical practitioners?

Dr GOLD — I think I have not quite answered your question properly. People with mental health disorders, if they are dying — and that would usually be for some other reason — without a doubt should have access to — —

Mrs PEULICH — But not just on the grounds of mental health — patients with depression or — —

Dr GOLD — Unfortunately the way people in those situations are dying tends to be either from something else — another disease — or suicide, and we do not really have an opportunity to intervene in that context. On the other hand there is an increased risk of suicide in people with terminal diseases or unrelieved symptoms, so the sectors need to work together, but I do not necessarily personally see a role for palliative care to be creating an end-of-life care situation for someone who is otherwise, I guess, physically well — —

Mrs PEULICH — But psychologically unwell?

Dr GOLD — Yes.

Mrs PEULICH — I just wanted to know your parameters. The second question is noting your anecdotal comments on the Exit Australia patient and how his goalposts changed, which is an entirely understandable human response, I guess, but in particular you noted earlier a different attitude towards death and you suggested that perhaps there may be a cultural overlay. I guess if you have been a refugee or an asylum seeker and your life has been under threat or if you have lost family to the Holocaust or if they have been extinguished by left-wing or right-wing regimes, a different attitude towards death may be understandable. Could you just comment on the cultural overlays in relation to attitudes towards death?

Dr GOLD — Again, working at the Alfred, Melbourne has one of the highest concentrations of Holocaust survivors worldwide, and certainly in Australia. We do get a flavour of that — that they are quite tenacious and really want to cling on and battle on. Certain religions also would have that as more in keeping with their religious beliefs. In Judaism it is seen very clearly that every second of life is important and not to be dismissed, and it is certainly not sanctioned to end life earlier than it needs to be. Those groups of patients certainly, I imagine, would never want euthanasia and are certainly very clear that they do not want anything that is going to end their life earlier.

The other group that is really interesting that we are starting to see as the landscape changes and treatments get better is patients who have survived an overwhelming illness or particularly had an organ transplant — where I work that is obviously one of the things. They find it very difficult, sometimes, when we are getting to the stage where the organ is failing or something else has happened — perhaps they have developed a cancer after that. They say, ‘But I have got through this one life-threatening disease, what do you mean I am not going to get through this next one?’. Their drive to keep living, hang in there, have more treatments and pursue every second of life is actually incredibly strong as well.

So there is a huge range of views in the community. I also try to be quite careful not to assume anything, because somebody might come from one particular cultural group but actually have a point of view that is not typical of that group. We need to know what each individual person’s belief system is.

Mrs PEULICH — Sorry, if I may ask one follow-up question, in view of the nature of humanity and often the love of living, not just for our own sake but perhaps in terms of children, grandchildren and so forth, is it unusual for people who may have been favourably disposed to an early, perhaps interventionist, death to change their minds and embrace the possibility of living more? Do people change their minds?

Dr GOLD — Yes, in both directions. When someone who has perhaps felt that they would not continue living beyond a certain point in fact happens to hit that point, they say, ‘Oh well, it is not so bad. I will keep going’. I mentioned one anecdote, but it is actually not an uncommon story. It is a little bit as if because things happen gradually, they are able to adapt and cope and therefore say, ‘All right, I can keep going’. But sometimes on the other side people who have battled on and put up with an awful lot in terms of the burdens of treatment reach their tipping point and say, ‘I just won’t do it’. You will also hear stories of people who just wait for something — a baby to be born or whatever it might be — and then say, ‘That’s done, I’ve seen my grandchild, and I am ready to just ease out now’.

The CHAIR — If I could ask a question, Dr Gold, I am interested to understand how patients come to be under your care. Are they generally pre-existing patients within the Alfred or do they come from other hospitals or in-home care?

Dr GOLD — At the Alfred we are an inpatient consultancy service. We do run a small outpatient clinic and it is theoretically possible for GPs to refer patients in, but that would be a pretty tiny number, so most of them are patients at the Alfred. Most of them actually have not been in contact with palliative care services previously, so we are commonly the first point of contact with palliative care.

The CHAIR — Dr Gold, thank you very much for your presentation and your answers to our questions this afternoon. It is greatly appreciated, particularly, as I said earlier, your practical perspective. Thank you very much. The transcript will be available to you in the coming days, and the committee thanks you very much.

Dr GOLD — Thank you.

Witness withdrew.