

# TRANSCRIPT

## STANDING COMMITTEE ON LEGAL AND SOCIAL ISSUES

### Inquiry into end-of-life choices

Mornington — 29 October 2015

#### Members

Mr Edward O'Donohue — Chair

Ms Nina Springle — Deputy Chair

Ms Margaret Fitzherbert

Mr Cesar Melhem

Mr Daniel Mulino

Ms Fiona Patten

Mrs Inga Peulich

Ms Jaclyn Symes

#### Participating Members

Mr Gordon Rich-Phillips

#### Staff

Secretary: Ms Lilian Topic

#### Witness

Dr Doug Gaze.

**The CHAIR** — I would now like to welcome Dr Doug Gaze from the Flinders Medical Centre. Thank you very much for being with us this afternoon. Before I invite you to say a few words, I will just 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 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 proof versions of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee's website. We have allowed about half an hour for our time today. We have received your submission — and we thank you for that — drawing on your 30 years as a general practitioner and your personal experiences. I invite you to make some remarks, and thereafter the committee will have some questions. Thank you very much.

**Dr GAZE** — Thank you, Mr O'Donohue. Thank you for the opportunity to put in a submission and also to be invited to speak today. I am here mainly for selfish reasons because I would like to see law reform in this area, but I do not have any axe to grind; I am not giving my views on behalf of anybody else. These are personal views which I have developed over my 25 years as a GP.

**Dr GAZE** — I have been practising in medicine since 1980, but the first 10 years were in a hospital. Also those views are honed by the experience of watching my wife die from pancreatic cancer in 2010 at the age of 53 and my mother from stomach cancer in 2012 at the age of 88. We were not able to have children, so they were the two most important people in my world.

I do believe the majority of the community want legislative reform in this area, and I think without some reforms certain patients will go on suffering intolerably and some will continue to take matters into their own hands with or without the help of the doctors, which exposes them to lonely and tragic deaths and those supporting them to the fear of legal retribution.

Briefly, my background: I graduated in 1980 in Melbourne, so I worked in the hospital system for 9 years and then in general practice since then, 21 years in Wangaratta until my wife's death and the past 5 years at Flinders. I have witnessed a lot of changes in that time with the growth of palliative care, and that has certainly been a great development and should be supported and improved. The value of good nursing care cannot be overestimated, but on a personal basis I think we have lost some of that over the years. I do not think nursing care is as it used to be.

Over my time I have been involved in the care of quite a number of people in their final illnesses, the majority of those being cancer deaths, and some of those deaths have been pretty gruelling. Some of the worst I have seen were advanced cervical cancer, which is something we do not see much of now; oesophageal cancer; prostate cancer; head and neck cancers; emphysema; and motor neuron disease. Some of those deaths were very drawn out and very difficult for all involved, and symptoms of course include intolerable pain — but in some respects pain is not the worst symptom because it can be managed generally pretty well — nausea, vomiting, bowel obstructions, severe oedema of the legs, jaundice with the unbearable itching that goes with it, pressure sores, faecal impaction and incontinence, ulcers, confusion, haemorrhage, choking et cetera.

Some of the deaths can be confronting and involve a lot of suffering. However, the majority of deaths that I have witnessed have been well managed with good palliative care. It is the ones that were not so well managed that stick in the memory, and those are the ones that drive my views. I am certainly not saying all of these patients would have chosen an earlier or easier way out if it was available, but some of them would, and many ask for it.

If we do not have legislative reform, then some patients will still take matters into their own hands. In my time in Wangaratta in our practice we had several patients who chose to end their own lives to escape the final stages of their illness, including one gentleman I particularly remember who had advanced prostate cancer and had been to his specialist. He had secondaries in his spine. His specialist told him there was a risk he would become paraplegic, following which he went home and shot himself. I would rather patients have another way out.

It is important, in my opinion, that the committee understands that although palliative care can well manage the majority of patients, it cannot manage the suffering of all patients, and that suffering is not just physical; some of it is psychological or existential or spiritual. That is influenced by a lot of factors, both intrinsic and extrinsic factors: people's beliefs, their personal resilience, their degree of family support et cetera. There is no doubt some patients, possibly a lot of patients, experience depression, but in my experience that is usually in an earlier

path of the illness and is often well managed, and it is not that hard to distinguish a depressed patient from one of clear mind with their clear wishes.

On a selfish level, personally I am convinced that if I was in the situation of having a terminal illness with no hope of recovery and the likelihood of significant suffering, I would prefer to have the choice of a way out at a time of my choosing and with the people of my choosing. I have thought about these issues more deeply since my wife died of pancreatic cancer. She was diagnosed five months beforehand. My wife was under an oncologist who had a great reputation for persistence and a reluctance to give up on active treatment, and one gets caught up in that. You have probably heard the term ‘denial’, and I think we both suffered a bit of that.

Her blood tests were improving, but as is the case often with pancreatic cancer, the deterioration was sudden and she got admitted to Epworth Freemasons in September 2010, sadly at the same time as her own private oncologist was becoming unwell himself. She was in there for five days without him being able to visit. He subsequently died of a rare illness. During that time she was not well managed at all, and she suffered quite severely, and I could not personally arrange any urgent palliative care. I tried to get her into Caritas Christi, but that did not occur.

In my mother’s case, she died of a condition called linitis plastica, which is a rare form of stomach cancer which infiltrates the stomach wall, and basically the stomach just shrinks down. She just could not eat, and she had intolerable nausea, and nausea is one of those symptoms that is quite hard to palliate. She was under very good palliative care, both at home and then in Caritas Christi for three weeks, but her symptoms were not well relieved. She asked me several times if I could do anything to put her to sleep, but of course I could not.

I have a few comments in other areas — advance healthcare directives and care directives. I think that is an important area. I think they are under-utilised. I think people do not understand them, and a lot of people do not want to know about them because they do not want to think about it. I do not really know what the legal status of them is, but I have noticed in recent years that more people are wanting to make advance health directives, and I certainly encourage them to do that and also to have an enduring medical power of attorney, but the most important thing around that whole area is that people make their wishes known to family, and clearly.

Regarding palliative care, I support adequate funding, training and availability of high-quality palliative care. When I trained, there was no such thing as the specialty of palliative care, and in those days death was seen as something to be denied and to be avoided at all costs. I think still some oncologists, in my experience — many are very good at this — probably do not know when to give up and implement palliative care appropriately, and I think there is a tendency to go on with sometimes futile treatments.

Terminal sedation versus physician-assisted death is an issue. We do currently practice a form of passive physician-assisted death by withdrawing treatments and increasing doses of morphine and midazolam, but that process can still take days, sometimes weeks, and can be quite gruelling. I do not see a fundamental difference from a more active form of physician-assisted death; I think the intent is what is crucial. But that said, personally I would have great difficulty giving somebody an injection which I knew had the effect of killing them.

But I think we can learn from other jurisdictions, and I would point out particularly that Canada and California have both enacted legislation this year around this particular area. I think there is a lot to be learnt. We do not have to reinvent the wheel. I found last night a very useful website in Canada called External Panel on Options for a Legislative Response to *Carter v. Canada*. That seems to have a lot of very good resources.

Just briefly, in summary, my personal belief is that the relief of suffering is the highest priority. I accept that many people have very vocal opposition to any change in this area, but I think suffering is the highest priority. I do believe there are solutions and safeguards to most of the arguments that are put up against law reform. I think we can learn from other jurisdictions. I do not see this as a slippery slope, but rather a compassionate response of a progressive and caring society to a very difficult issue.

Finally, I quote the words of Governor Jerry Brown in California, who when he signed these bills three weeks ago, in October, said:

I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by this bill. And I wouldn’t deny that right to others.

**The CHAIR** — Thank you very much, Doctor, for a really considered position. I would like to take you to your comments that palliative care cannot manage the suffering of all patients, because it has been put to us by numerous witnesses that the desire of people who seek voluntary euthanasia is partially borne from a misconception about palliative care and what can be achieved through good palliative care. You, in your statement, in effect reject that assumption, but I would like to put that proposition to you — —

**Dr GAZE** — I do not reject it, but it does not work for everybody. We are all individuals, we all suffer differently and we all have different choices. The reality is that although it can relieve a lot of the symptoms, I do not think it can relieve all the suffering. That is where this whole issue really resonates. How do you measure suffering? I can only talk from my opinion, because I am not one of the ones who I have seen suffering, but I have seen how gruelling some deaths are, despite the best that palliative care can give. And I think even the experts you would have consulted would have said that at times the only thing they can do is basically render people unconscious to relieve their symptoms, at which stage they will progressively die from basically lack of intake of fluids, and that is the way it is managed. I guess that is my response.

**Ms PATTEN** — One of the comments that is brought to us when we talk about this is ‘Palliative care is doing very well. We’re going in leaps and bounds there’, but, yes, it cannot relieve everyone. Then you could go on to say that it is only a small percentage, and the opposition to that is, ‘If it’s just such a small percentage, why are we introducing legislation? Why would we want to introduce legislation for such a small percentage of people?’. Do you have a response to that?

**Dr GAZE** — Well, I am not sure that it is such a small percentage. My understanding is that it is in the vicinity of 5 to 10 per cent, but I do not have any particular expertise to quote on that. But these are the people who take it into their own hands sometimes, and I do not know if we are a society that wants to see that sort of thing happen. I am not sure, but I think you have had submissions from the Coroners Court and I am sure you would have heard that a number of people do. I think that is a difficult issue. It is not an easy issue — I am not saying it is, and I am not saying that there is an easy answer. But where do you draw the line with the individual versus society, particularly when I think that it is probably the view of the majority of people — but I know it depends on how the questions are asked. In the UK this sort of legislation has been knocked back this year, but I do think the polls that were done still had in the vicinity of 70 per cent public support for the concept of a form of physician assisted dying law.

**Ms PATTEN** — And interestingly in the UK the courts have made a precedent that they will no longer prosecute or convict someone who has assisted in a suicide, as long as they are not a doctor. So the individual is now protected, but not the doctor.

**Ms SPRINGLE** — You go into your support for legislation that has been introduced overseas around this, and it appears from your submission that you prefer the North American models as opposed to the European models. Could you explain a little bit about why?

**Dr GAZE** — I am not sure that I do. I just mention them as recent jurisdictions that have legislated. I know that several European countries have had this sort of practice for some time, and I am sure there are a lot of lessons to be learnt from all these places. I think Canada is interesting because it is a very similar sort of society to ours, as is California. I think Canada is going through the process of trying to decide how this could be implemented. It has not come in yet, but that is probably where I think we could learn.

**Mr MULINO** — Thank you very much for your submission and your testimony today. I was interested in one observation you made in relation to some of those cases where pain relief is an option but sometimes nursing staff might be reluctant to give adequate doses because of repercussions. We have heard somewhat mixed evidence, I think it is fair to say, from the medical profession. Some people have said that medical professionals sometimes do worry about that and might not give as much assistance as they might be able to, or may not be able to use the full range of options. Other people said that it is not so much of an issue. Do you think it would be a beneficial reform to provide more clarity to protect medical professionals?

**Dr GAZE** — Yes, absolutely. I think it would be, and it is probably less of an issue nowadays because there is more understanding of palliative care. It certainly used to be, particularly in nursing homes in Wangaratta. People could be suffering quite a lot, and the nurses would just give the smallest dose of morphine just occasionally because they were worried what would happen. You are not generally going to kill anybody by giving them an appropriate dose of morphine to relieve their suffering. So I think that is a good point.

**Mr MELHEM** — Thank you, Doctor. You have talked about voluntary euthanasia, particularly in relation to terminal illness, chronic disease et cetera. What about the case of mental illness, for example? Twenty-five-year-old, suicidal but physically otherwise well, would you apply the same principle across the board?

**Dr GAZE** — No, I would not, absolutely not. I know that has been a contentious issue in recent times, but no, I do not think I would, and I think some of the legislation in Belgium has probably gone far too far along that line. I would not. I think there should be very strict criteria, and I think there are a lot of difficulties around that issue. I do not even think for somebody suffering from advanced dementia, unless we are bringing in advance care plans which have enough legal status to carry weight in that area. I think basically somebody has to be obviously of a clear mind over a period of time, and without mental illness or other obviously external pressures or factors. I have not really thought through the process very deeply, but I gather that is the sort of thing that some of these other jurisdictions have thought through.

**Ms PATTEN** — Terminal sedation versus physician-assisted dying: I think you quite eloquently put it in your submission today. If we were to allow physician-assisted dying, do you think there would still be a role for terminal sedation? Would they both sit alongside each other?

**Dr GAZE** — Absolutely there would be. I think that is probably one of the things that I should have pointed out. I think there are examples of people such as Peter Short, who you may or may not be aware of, who has had access to Nembutal but not utilised it, and I have actually had one patient in my care who was able to obtain a little bottle of Nembutal, and they never used it. But I think it was comforting for them to think that they had that there and they had some sense of control, and I do not think any of us can really say how we would feel in that situation. Sometimes, by taking the process and going through the care, people can go through the whole process and have reasonably good deaths.

**The CHAIR** — Is there anything else, Doctor, that you would like to add before we conclude?

**Dr GAZE** — No. I wish you well with your deliberations, and I think it is good that we have got this on the table and I look forward to seeing results.

**The CHAIR** — It is, and we appreciate hearing from people like yourself who have had both personal experience but also medical experience, so thank you very much for your evidence today and for being here with us.

**Dr GAZE** — Thank you.

**Witness withdrew.**