

# **JOINT SELECT COMMITTEE ON END OF LIFE CHOICES**

**INQUIRY INTO THE NEED FOR LAWS IN WESTERN AUSTRALIA  
TO ALLOW CITIZENS TO MAKE INFORMED DECISIONS  
REGARDING THEIR OWN END OF LIFE CHOICES**



**TRANSCRIPT OF EVIDENCE  
TAKEN AT PERTH  
FRIDAY, 13 APRIL 2018**

**SESSION FOUR**

## **Members**

**Ms A. Sanderson, MLA (Chair)  
Hon Colin Holt, MLC (Deputy Chair)  
Hon Robin Chapple, MLC  
Hon Nick Goiran, MLC  
Mr J.E. McGrath, MLA  
Mr S.A. Millman, MLA  
Hon Dr Sally Talbot, MLC  
Mr R.R. Whitby, MLA**

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**Hearing commenced at 1.38 pm****Dr RODNEY SYME****Medical Practitioner and Vice President of Dying With Dignity Victoria, examined:**

**The CHAIR:** On behalf of the committee, I would like to thank you for agreeing to appear today to provide evidence in relation to the end-of-life choices inquiry. My name is Amber-Jade Sanderson and I am the chair of the joint select committee. We have Hon Dr Sally Talbot; John McGrath; Dr Jeannine Purdy, our principal research officer; Hon Colin Holt; Hon Nick Goiran; and Hon Robin Chapple. The purpose of today's hearing is to discuss the current arrangements for end-of-life choices in Western Australia and to highlight any gaps that might exist. It is important you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything you might say outside of today's proceedings. I advise that the proceedings of this hearing will be broadcast live within Parliament House and via the internet. The audiovisual recording will be available on the committee's website following the hearing. Do you have any questions about your appearance today?

**Dr SYME:** No; I am very happy to appear.

**The CHAIR:** Thank you. Before we ask any questions, did you have a statement that you wanted to make for the committee?

**Dr SYME:** I planned just a few brief notes that might be relevant. I have no intention to change the submission that I made earlier to you, but, I think since I made that submission, the Victorian Parliament has passed legislation on the issue of voluntary assisted dying. I am sure that your inquiry would be aware of that. The legislation is of a very conservative kind. You would, I think, probably be looking at it to model. It may be helpful to make some comments about the legislation from my point of view as a medical practitioner and as the vice president of Dying With Dignity Victoria. The legislation confines assistance to people with a terminal illness with less than six months to live, with one exception, and that is people with a neurodegenerative condition. I argued strongly for a wider period of illness, for the simple reason that neurodegenerative illnesses are very slowly progressive and the suffering associated with them can last at least 12 months, unlike cancer, in which the terminal phase is a very much shorter period usually and can be reasonably well palliated, whereas neurodegenerative conditions cannot be well palliated. There is a secondary group of people who I think should be considered in this 12-month exemption, and those are people with chronic organ failure. Here, I am speaking particularly of people with cardiorespiratory failure. The trajectory of their illness is quite different from those of people with cancer and very similar to people with a neurodegenerative illness. People with cardiorespiratory failure can have a terminal illness—the trajectory may be at least 12 months—interspersed with episodes of acute failure. With appropriate medical treatment they can respond and then go on with their chronic illness, but probably more severely disadvantaged. But I think the Victorian legislation is a little restrictive in not at least considering those people as part of the exception to the six months terminally ill criterion.

The other point that I think is very important to consider is the difference between the state of Victoria and the state of Western Australia. I do not know the exact figures, but I would imagine that Western Australia is possibly up to 20 times as large as Victoria, so you will have people who are in very isolated areas who will find it difficult to readily obtain two independent medical

opinions, as is required under the Victorian legislation. I am not suggesting that there should not be two independent medical opinions, but geographic problems will need to be considered in your considerations. I would urge you to consider the use, and include in the legislation if it goes ahead, of video interviewing rather than the necessity for personal interviews. You can imagine somebody in an isolated area of Western Australia could find it extraordinarily difficult to obtain two independent opinions without significant travel at a time in their life when that is a huge burden to them. The other thing which I think should be considered in addition to the Victorian legislation is that you should include the question of creating a register of doctors who are supportive and a register of doctors who are not supportive. Presumably most of those will be on moral grounds, and that is perfectly reasonable and acceptable. There will be people who will make a request for assistance and who will be denied, and who will then find it very difficult to know where to go to find a medical practitioner who is supportive, particularly if the first doctor rejects the request on moral grounds. I think some mechanism should be included for assisting patients to find doctors who are prepared to assist; otherwise, there will be many people who will be discriminated against.

The final point I would like to make in that respect is that the Victorian legislation makes no recommendations regarding medication that would be used. This is a serious issue. I do not think it is the place of legislation to make recommendations about what medication should be used—that is a decision for the doctor and the patient—but the evidence from all areas indicates that a quick-acting barbiturate, if assistance is to be provided, is, without any doubt at all, the optimal method of medical management. At the present time, that is a difficult matter. The doctors cannot prescribe the drugs and the Victorian government will have work to do. I hope that the Western Australian government, if it proceeds to pass legislation, will join with the Victorian government and make sure that the best possible medical treatment is available if legislation is considered and passed. To fall back onto some half-baked combination of prescribable pharmaceuticals will be of very little benefit to anybody.

The last thing I would like to say is that your committee should recognise in the broadest of senses the benefits that would come from legislative change. You may think that this is legislation, and people in Victoria probably think that this is legislation, that will affect just a few people. It is estimated that a couple of hundred people will use the legislation per year in Victoria. That will be the limited benefit of it. I suggest to you that the benefits are far more widespread than that. The fact is that at the present time it is very, very difficult for doctors and patients to have open, honest conversations about end-of-life issues, because the impact of the law sits on the shoulder of the doctor and he is inhibited in what he can discuss, what he can say and how he can engage with that patient. The passage of legislation will not just affect those people who use medication; it will have a profound effect on the ability of doctors and patients to communicate with one another about their end-of-life issues. That very honest and open communication will eliminate many of the necessities that people think they have for assistance. The ability of this legislation to provide a sense of peace and comfort for the whole community should not be unrecognised. A third aspect, I think, will be the important impact of this legislation on palliative care in the longer term. Palliative care does a wonderful job in most instances, but when it comes to the sharp, pointy end of end of life, they do find it very difficult to provide the type of treatment that many people want. The impact of this legislation in opening up wider discussion I think will improve palliative care and will lead to what is called in, for example, Belgium, integrated palliative care, where people in palliative care now have a far greater choice than they do here at the present time.

**The CHAIR:** Thank you very much, Dr Syme. Just referring to your submission to the committee, you outlined a number of models for voluntary assisted dying in various places around the world. We

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have heard evidence that those models have been subject to the slippery slope in terms of broadening the categories of people eligible. Do you have a view on that?

[1.50 pm]

**Dr SYME:** Well, I think the slippery slope argument does not stand up to scrutiny. In all those legislatures overseas where assisted dying is possible, there is no evidence of a slippery slope. The Canadian Parliament found that that was the case. All the evidence put to them through the Supreme Court in Canada indicated that there was no evidence for that. The fact is that there have been changes in some of the practices in other countries; for example, the Netherlands and Belgium. But that is based on the fact, which is not often recognised, that the Dutch and the Belgian legislation has as its entry point the question of intolerable suffering, not terminal illness. As I have already indicated to you, intolerable suffering can apply to people with neurodegenerative illnesses, chronic cardio/respiratory failure and other organ failures. In my experience, which is very extensive, it can even apply it to people with chronic pain which the medical profession is completely unable to relieve. That is a circumstances which I would hope all of you on this committee would understand—living with chronic pain, day in, day out, which affects your ability to be employed and your ability to maintain any quality of life. I have worked in these areas with the workers' compensation system in Victoria and the transport accident board. It affects sexual function to a huge degree. For many of these people, their lives are rendered a very poor quality. Suffering is the issue, not terminal illness, let me tell you. The entry point in those jurisdictions overseas is intolerable suffering. Most of those countries initially regarded terminal illness as the critical point, but in fact the legislation was broader than that, and as time has gone on they have understood better the question of intolerable suffering. As a result, some other conditions, such as those I have mentioned, have come to be included in the criteria of acceptance. That is not a slippery slope; that is simply a better understanding of the nature of the legislation. For example, another change that has occurred is that in the Netherlands and Belgium they had passed legislation. This I an important point: if you pass legislation after careful debate in your Parliament, that is not a slippery slope; that is reasoned argument. In those countries they have extended the legislation to include some older children. Would any of you think for one single moment that suffering can only occur for people over the age of 18 and that it cannot occur for people who are younger? If you speak to experienced paediatricians, they will tell you that intolerable suffering occurs in a significant number of children under 18 with a severe illness. The added experience of that is that for those children, whilst they might be considered minors, the basis of their experience with serious illness increases their ability to comprehend serious issues way, way above those of most of their peers. Their experience with serious illness alters their perception and expands their ability to make serious decisions in this regard. These changes have happened, but they are not examples of a slippery slope in any sense of the word.

**Hon NICK GOIRAN:** Dr Syme, do you recommend that child euthanasia be introduced in Western Australia?

**Dr SYME:** I do not use the word and I do not recognise the word “euthanasia”, because that implies people using a lethal injection. I prefer the term “voluntary assisted dying”, which is the terminology used in the Victorian legislation. The Victorian legislation only allows for self-administration. I do believe that there is a very reasonable place for allowing children under 18 who have got the mental capacity to make these decisions, that that could be allowed, but in saying that, I do acknowledge that politics is the art of the possible and all of you politicians face the difficult issue of reaching a piece of legislation which will be acceptable to everybody. The Victorian Parliament decided that was a step too far. I accept that, but at the same time I do believe that not extending the legislation

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to children of mature age and capacity can be discriminatory. I believe that is the case. Whether you can argue that in your Parliament is a question for you to consider.

**Hon NICK GOIRAN:** Thank you for your honesty.

**The CHAIR:** Dr Syme, I am interested in exploring your comments about including people with chronic organ failure. We have not had a lot of evidence to that effect, so I am after a bit more detail from you of what kind of conditions and what the trajectory of those illnesses are that should be included.

**Dr SYME:** It is common knowledge in the medical profession that people who have chronic heart failure will have a trajectory. I refer you to the work of Dr Lynn in the United States, who has studied the trajectories of terminal illness. It clearly illustrates that people with cancer will go along with a reasonable quality of life until somewhere between three to six months before they die, and then their quality of life plummets quite dramatically. With chronic heart failure, due to a variety of causes the trajectory is prolonged. Similarly with chronic respiratory disease. Chronic obstructive respiratory disease is a typical example. Chronic pulmonary fibrosis is another. These people can live for even two or three years with extreme respiratory distress, because the trajectory of the disease is very slow. You must have seen people at times who are connected to an oxygen cylinder with a mask. Their ability to move about is limited to the space of a single room; they can barely go beyond that. They can live in that fashion for months and months and months, in extreme distress and with negligible quality of life. I have had people of that nature request assistance from me to help them in the end of their life. Their quality of life can be appalling for them. That is important; it is for them. These are personal decisions which individuals will make. Not every person with chronic respiratory failure will make that decision. It is a courageous decision for anybody to have to make to face the question of their own mortality, but there are people who will do that. If there is a very, very clear indication after prolonged communication—I make this point very strongly: these are not decisions, in this particular group of patients, which should be in any way rushed. They should be as a result of prolonged communication. I believe in this category of patient it is the one area where I do indicate that a psychiatric assessment should be made. Not in other areas at all, but in this case it is important to be sure that this decision has not been made as a result of the burden of depression. But for the majority of people, that is not significant.

**Hon ROBIN CHAPPLE:** One of the issues that cropped up is this whole time line issue. Obviously, you are saying there that for the people who have chronic illness, the six-month time line does not work. Do you have a view of what model around time lines in this area should reflect? Is the Victorian model okay or should we actually have another definition or another process around the time lines?

[2.00 pm]

**Dr SYME:** I think you mean that the six-month critical illness criterion will be effective for the vast majority of people, but I make the point that there are exceptions to that, and the neurodegenerative illness and the chronic organ failure are two particular examples. Many of those in the Victorian Parliament recognised neurodegenerative illness as an exception and made an exception in their legislation for that particular type of condition. I would argue that there is still discrimination in the Victorian legislation in that it ignores people with chronic organ failure. I think if you extend it or you include it into your legislation, if that is the recommendation you make, it should also include people with chronic organ failure, specifically people with cardiorespiratory failure, and that this group of people could be considered in the 12-month exception. I think the legislation in that sense would be less discriminatory than the Victorian legislation.

**Hon ROBIN CHAPPLE:** Further to that, Dr Syme, where do people with motor neurone disease fit in the process?

**Dr SYME:** They would fit in the chronic neurodegenerative category, and they are there because that is a disease which is slowly progressive. They could be in a position before the six-month terminal illness criteria are reached where they are unable to talk and communicate, unable to swallow and suffering from a progressive degree of respiratory failure. To suggest that they should wait until somebody decides that they have six months or less to live is to impose a severe burden upon them. The same argument applies, as I say, for people with more direct cardiorespiratory failures. These are slowly progressive conditions which leave people severely debilitated for a long period of time. My own experience of counselling over 25 years includes a number of these people.

**Hon ROBIN CHAPPLE:** Further to that, we have heard evidence that certainly motor neurone disease can be many years if not months, so to have that extension of 12 months for people with motor neurone disease, is that enough time?

**Dr SYME:** There is a problem here and it applies across the whole board, and it is that no illness is absolutely identical in all individuals and so there will be some people with motor neurone disease who may, beyond the 12-month period, have intolerable suffering. With the early phases of motor neurone disease, it is a disease which evolves, for most people, over about a five-year time span. But the first three to four years are those of progressive paralysis of the limbs. Most people can cope with that. Let me assure your committee that the vast majority of people, no matter what their illness, want to go on with their lives as long as they possibly can. I have helped a lot of people at the end of that life and it has always been my fundamental belief, or approach, to try to help people to go as far with their lives as possible. I believe that that will be the attitude of the majority of medical practitioners who become involved in assisted dying. Doctors are a conservative group; they will not want to be helping people with assistance to die without very, very due cause.

My experience is simply this: people with motor neurone disease in the early stages do not wish to end their lives, nor would I be likely to provide them with that assistance; I would be, in fact, helping, trying to provide them with reasons to go on with their lives. But once you are reaching a phase of motor neurone disease where you have lost the ability to communicate, you are finding it difficult to swallow food and fluids, you are choking on your own saliva or your breathing is becoming so distressed that you cannot maintain it without assistance, this is the stage when most people with motor neurone disease request some assistance. That can occur earlier than the six-month period; that is the point.

**The CHAIR:** Dr Syme, we have had some evidence that there should be no restrictions on the time of death, and that is the case in some jurisdictions. What do you think of that?

**Dr SYME:** I do fundamentally believe that suffering is the critical issue. The time of death, to my mind, is a structure which has proved to be what I might call politically acceptable to Parliaments. But the simple medical fact is that if suffering is the reason why people request assistance to die, not how long they have got left to live, then suffering is not confined to people with a particular period of time to live. As I have tried to indicate to you, there are a number of people who will be going to die in a lot longer than six months, but they have intolerable suffering. But, again, you come back to the political question: What is acceptable to you people as politicians? What is possible to be passed as legislation? The Victorian committee and the Victorian Parliament accepted that for legislation to be accepted by the community and by the politicians, there had to be a limitation, and it was accepted that the legislation in Oregon of six months was to be the model. I do not disagree with the fact that that is a reasonable model, but I will make the point that it is discriminatory against some people with some illnesses who will have grievous suffering who will not qualify under that legislation.

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**Mr J.E. McGRATH:** Further to that question, and then I have one other question, could you have a system where you maybe have the six months but you allowed for the implementation of some policy where people in an exceptional circumstance could maybe make a claim to the medical authorities or whoever was going to grant that approval?

**Dr SYME:** I believe you could; you could write that into legislation. The norm would be for a six-month period but recognising that there are exceptions. You could legislate to say two doctors—in this particular realm, I believe that there is a role for a psychiatrist to be an additional consultation, because you are now looking at a longer period of possible cessation of life and there is a need there for it to be in the highest standard, if you like, of scrutiny. For somebody who has cancer and who is going to die in a month, for god's sake, asking them to go through a psychiatric assessment is a barbarous process. But for somebody who might have an unpredictable, necessarily difficult to predict period of future existence, there is a higher standard necessary to be sure that this person is not being motivated by a severe degree of depression. If you were going to make an exception of that sort, I think it would be reasonable to mandate that they would have a psychiatric assessment which said, "Yes, this person is of sound mind; they are not influenced by depression", and if two other doctors were in agreement that this suffering was of such a degree that it needed to be relieved, you could write that into legislation with careful practice.

**Mr J.E. McGRATH:** Earlier you mentioned a register of doctors who are supportive and maybe those who are not supportive. Is this included in the Victorian legislation; and, if not, is that something that you think should be included?

**Dr SYME:** No, it is not, but I think it should be. Let me say that under the Victorian legislation, many patients may face a difficult task to achieve their request. I believe, quite rightly, the Victorian legislation says that doctors may refuse to accept a request on moral grounds, and I think that is appropriate. But if your general practitioner, for example—who I think should be the appropriate person for the initial consultation—says, "No, I won't help you", and, more than that, says, "and I can't advise you who else you might see", you can imagine that patient is now in a sort of limbo. Where are they going to go to get advice?

[2.10 pm]

We have in Victoria a situation where certain religious-based hospitals have said they will refuse to implement any activities under assisted dying. The patients there will be out of a limb. Those hospitals and institutions are yet to indicate what sort of policy they will have with regard to onward referral of such people. It would be retrograde to have a piece of law in which people can have their request refused and then have no easy or acceptable or reasonable further avenue to find, particularly if the doctor says, "Look, I can't agree with your request because you don't fill the requirements." That is straightforward. However, if they say, "I can't fulfil your request because of moral reasons", where does the patient stand to find another doctor who will listen to their request in an open way? So to have a register of people, if a doctor is not prepared to accept a request, then I think that ought to be recorded and patients can find another doctor.

**Mr J.E. McGRATH:** You do not think the Victorian Parliament might have been a bit concerned that doctors who were advertised as being supportive might be cast as the "Dr Death" of Victoria and could have protest groups outside their surgeries like we see sometimes with abortion clinics? Is that maybe one reason why you think they did not put in a register?

**Dr SYME:** I have no idea why they did not do that. As you know, it is a very difficult process to get this sort of legislation through a Parliament. It is more an administrative matter, in my view, than a legislative matter, but it would not be beyond the possibility for a Parliament to suggest or have that kind of an administrative process. I have been called "Dr Death" for many years, let me tell you!

It has not prevented people from approaching me for advice, nor has it affected my practice in any way, shape or form. I have advised people because I believe it is the right thing to do in my conscience. Nobody should have to suffer intolerably beyond their limits. There is no logic to that and I do not think it is something we should accept in our twenty-first century.

**Hon Dr SALLY TALBOT:** Dr Syme, when it comes to the question of assessment of capacity, which we are pretty much agreed is essential to this kind of scheme, and then given the intricacies of deciding on a timeline, what can we offer people with dementia in terms of assisted dying options?

**Dr SYME:** The Victorian legislation has excluded them because, whilst they have capacity, and people in the early stages of dementia can have capacity, if they are terminally ill but they are not going to die within six months. A person with dementia who has capacity will probably survive for another four or five, and possibly even more years. Dementia is the most difficult medical condition to deal with under this sort of approach. They cannot manage it, despite the fact that in the Netherlands they have been dealing with this effectively for over 35 years. We have not managed to really come to grips with the issue of dementia. In my opinion, it is the worst disease known to man, but it suffers from the extreme difficulty that by the time the person has truly intolerable suffering from their dementia, they are quite incapable of making any decision. I think it will take a lot of time for this issue to be resolved by humanity. My wife is currently suffering from dementia, so I am acutely aware of the problem, quite apart from my affirmative views. It is a tragic disease which we need to continue thinking about, but I do not think it is really effectively possible at the present time to include people with dementia in legislation. ‘

**Hon NICK GOIRAN:** Dr Syme, just to pick up on the topic that you were discussing with my colleague Mr McGrath on the register for doctors, is that to be a register for doctors practising in this area or a register of doctors who support it?

**Dr SYME:** No. It would be register of doctors who would be prepared to take requests in a genuine manner. The outcome of the request is dependent upon the criteria that are in the act. For example, Dr A might have a moral objection to acting in any way under the legislation if it were passed. People need to be aware that that doctor has a moral proscription against providing any form of assistance, and if that particular doctor is their general practitioner, they are running into a brick wall, are they not? They need to know, if they have any desire to make a request, that there is no point in going to see that doctor because he has a moral objection, prior to any consideration of the physical status, mental status or whatever of their patient. All right, I admire the mostly Catholic institutions, hospitals et cetera, who have said, “We will not give people support under this legislation.” I think it is appropriate that they should say that—if they are not going to do it, they should make it known. In the same way, doctors in general practice, for example, who have a moral objection should make that known so that their patients can go in another direction if necessary.

**Hon NICK GOIRAN:** Yes, I understand your rationale for a register. I was keen to know whether the register should be of doctors who support what I describe as voluntary euthanasia—I know that is a term that you are not enthusiastic about—or whether it should be doctors who wish to opt in and practise in this area. I think I am hearing you say that it is the latter—that it should be those who are opting in to practise. If that is right, should there be any form of certification or professional development or training of any sort for such doctors before they are registered?

**Dr SYME:** Absolutely. There is no question in my mind that there needs to be a very, very serious process of medical education around the legislation, if or when it is passed. The fact of the matter is that the vast majority of doctors have very little, if any, experience in relation to voluntary assisted dying. The majority of doctors have been inhibited from having the sorts of conversations that would need to take place once this legislation has been passed, because they have been inhibited

in the past from having those conversations due to the impact of law. Doctors do not have the experience or the training to be initially involved. That is why the Victorian Parliament has put in place an 18-month suspensory period from the passage of the law until it actually comes into operation. That is very important, in my opinion, to allow time for the education of the medical profession as to how the legislation works, how to conduct these conversations with people, what sort of medication to provide, and what sort of advice to provide patients. The whole process is not simple. It is complex, and doctors need training in that respect. In addition, the public need to be educated as to what the law allows and does not allow, and what sort of conversations they can have with their doctors.

To pass a piece of legislation like this and then expect it to work immediately in the community is, I think, not acceptable to me. I think you do need to allow time to set up the administrative processes, regrettable though it is that some people in the 18-month hiatus will perhaps suffer, unfortunately, without relief. Nevertheless, if you are going to pass legislation, it is important that you pass it into a society in which the public, the medical profession, the legal profession—the whole box and dice—are well aware and educated as to how it will operate. Then it will operate smoothly and effectively.

[2.20 pm]

**Hon NICK GOIRAN:** Earlier in the hearing, you mentioned some of the challenges in terms of the types and accessibility of medication and you mentioned it would be a retrograde step if we ended up with a half-baked combination. What is a half-baked combination?

**Dr SYME:** Well, if you are relying on the commonly prescribed pharmaceuticals that can aid death, you are looking at drugs like opioids and sedative drugs. I might point out that these are used not uncommonly in palliative care. Palliative care has a practice of what is called terminal sedation of people who would otherwise qualify under voluntary assisted dying legislation, if they requested it. Under current circumstances, they are provided with terminal sedation for their intolerable suffering, which means that they are given a gradually increasing dose over a period of time of titrated medication with opioids and sedatives, which means they are gradually put into a coma without food and fluids and they die in a coma without the ability to say goodbye to their family. They die in medical care. It is a highly medicalised form of death and yet that is totally legitimate in our society. That is the mode in which many, many people are helped to die by their doctors. I just put to you the contrast between that sort of a death, which takes place over maybe four or five days, sometimes longer, in an institution, not in the home, and it may be that they die in the middle of the night and their family is not present. You compare that with a death where a person, after due consideration and careful discussion with their family, decides that their time has come and they can decide to die in their own home, surrounded by their family, able to say goodbye, and then they will take an appropriate dose of a quick-acting barbiturate. They will go to sleep peacefully in two or three minutes and then they will gradually get deeper and deeper into coma and die in 15 or 20 minutes. It is a profound experience. It is one that they share with their family. The end of a life is a very important moment. I suggest to you that there is a stark contrast between what we are doing now to people at the end of their life and what could happen if proper legislation is passed.

**Hon NICK GOIRAN:** In your submission you say —

Occasional requests are from people with a chronic, longstanding psychiatric illness which has become unresponsive to treatment. They are beyond my competence and are referred for further expert treatment.

How do you determine which patients are within or beyond your competence?

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**Dr SYME:** These are people who on interview are clearly not suffering from a physical illness. They are suffering from a psychiatric illness. I have no expertise in psychiatry and, therefore, it is not appropriate for me nor, I suggest, would it be appropriate for a general practitioner or any other expert, to provide them with assistance. That would be an area for psychiatric experts. However, the Victorian legislation does not allow assistance to those people. That is a contentious point. The Netherlands have dealt with this issue through the courts and the courts have determined, and I agree, that a person with a severe, chronic psychiatric illness, which has been present for years and years and has been resistant to all treatment, may very well have severe intolerable suffering. You know, our suffering occurs in the mind. A very famous Australian psychiatrist, whose name escapes my mind—he developed lithium for manic depression—said that depression is the most painful illness known to man, equal in severity to somebody suffering with cancer.<sup>1</sup> It is undeniable that some people with chronic, untreatable psychiatric illness have the most severe suffering. Nevertheless, the Victorian Parliament decided that that was not to be part of the criteria, and I bow to their judgement, although, in my opinion, there is a sound argument for including such people, but that is a political judgement. Whether it is acceptable to your parliamentarians and the public is another matter.

**Hon NICK GOIRAN:** In your submission, you also note that you receive requests for assistance from —

... people who are suicidal, in the commonly accepted use of that term, for a wide variety of reasons, and are directed to the appropriate care.

How do you determine that someone is suicidal and how do you differentiate that person from others to whom you offer assistance?

**Dr SYME:** In exactly the same way as I assess every person who comes to me requesting assistance or any doctor would assess any person with any physical ailment. You engage them in communication. You talk to them. It might surprise you to hear me say this, but doctors are in some ways detectives. We engage people in discussion. We interrogate them. We find out what it is that is concerning them. We go back and we rechallenge that information again and again until we are absolutely certain of the facts and the basis on which you can make a diagnosis and offer treatment. So, it is not at all difficult when a person comes in and says, “I want to end my life” and I ask them why and they say, “I am hearing voices”. It is just fundamental good medical practice. Most doctors are readily able to decide, “Well, this person is suicidal”. I draw the distinction between “suicide”, which is the only word we have in the English language for somebody ending their own life.

Suicide in the generally accepted sense is somebody who is probably physically well, severely mentally disturbed, cannot see a way out of their dilemma, and, as a result, ends their life often in a very violent manner, the result causing great grief and disturbance to everybody who knows them. With voluntary assisted dying we are not talking about that circumstance; we are talking about somebody who is already terminally ill, who has discussed this matter in detail with their family. Every time I have had somebody come to me with a request for assistance, I have always insisted, although it may have potentially led me into difficult territory, that their family become part of the discussion. People who are going to end their life because of terminal illness, their family need to understand why they are taking that decision and to ultimately become supportive of it.

**The CHAIR:** Dr Syme, we are running short of time. I will go to Robin Chapple who has a few more questions.

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<sup>1</sup> Correspondence from the witness clarifying this part of the transcript can be accessed on the committee webpage.

**Hon ROBIN CHAPPLE:** Mine is actually quite a short one, really. We have heard the issues of self-administration, we have heard the issues of doctor administration and then we have heard the issues of what we call a doctor-prepared self-administration, al la the Northern Territory model where a pump was fitted, but it was still self-administration. Do you have a view—should one have all the gambits or should we have doctor-assisted voluntary assisted dying or self-administration—your views?

**Dr SYME:** I am absolutely convinced that self-administration is the appropriate thing for a number of reasons, but principally because that places control over the end of life firmly and totally in the hands of the individual. That individual will not end their own life unless they are faced with truly intolerable circumstances. Let me tell you that the majority of people want to live as long as they possibly can and they will only take this decision if their situation has become absolutely intolerable. What is more, I would suggest to you that the responsibility for this action should lie with the individual. I as a doctor—my responsibility is to try to help you to go as far with your life as I possibly can. But if you feel you can go no further, I have a responsibility to help you to have a peaceful death. If you want to end your life, that is your responsibility. If you want to end your life, it is your responsibility to take that action if you are physically capable of doing so. It is not proper, in my opinion, for you to think that you can pass that responsibility to me. It is the greatest safeguard that you can have in legislation to put the onus on the individual if they want to end their own life because of their intolerable suffering, and that is their responsibility and the safeguard is that they have to do it themselves. If somebody else can do it, there is a little less safeguard. But there are a few people, not many, who are simply not physically capable of self-administering and in that case I think you should have an out clause in which if they are unable to self-administer, then in that circumstance the doctor should be able to administer the medication.

**The CHAIR:** Dr Syme, thank you very much for your time today and for your evidence before the committee. A transcript of this hearing will be forwarded to you for correction of transcription errors. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period it will be deemed to be correct. New material cannot be added via these corrections and the sense of what you said cannot be altered. If you wish to provide clarifying information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your transcript.

Again, thank you very much for your time today and for your submission to the committee. It is very helpful.

**Dr SYME:** My pleasure.

**Hearing concluded at 2.32 pm**

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