

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
THURSDAY, 1 MARCH 2018**

SESSION THREE

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**

Hearing commenced at 12.15 pm

Professor WENDY NAOMI ERBER

Executive Dean, Faculty of Health and Medical Sciences, University of Western Australia, examined:

Associate Professor KIRSTEN AURET

Academic in Palliative Care, University of Western Australia, 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 Col Holt; Hon Nick Goiran; Reece Whitby; 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 may exist. It is important that 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 that 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.

Could you please both introduce yourselves for the record?

Prof. ERBER: Professor Wendy Erber, executive dean of the faculty of health and medical sciences at the University of Western Australia.

Prof. AURET: I am Kirsten Auret. I am an associate professor of medicine and deputy head of the rural clinical school and a practising palliative care physician.

The CHAIR: Do you have any questions about your attendance here today?

The WITNESSES: No.

The CHAIR: Before we begin with our questions, would either of you like to make an opening statement?

Prof. ERBER: Thank you for the opportunity. Professor Auret and I are here to represent the University of Western Australia and the faculty of health and medical sciences. We will not be presenting our own personal views, but those of the university and the faculty. As outlined in the written submission that we made, which was dated 19 October 2017, our faculty teaches into a number of health programs, but probably of major interest today is our medical program. We also teach dentistry and a number of disciplines within allied health, including pharmacy and social work. Our students are taught by a diverse range of academics, as well as clinicians, and I am here talking of the medical program, and, of course, they all hold their own personal views and have a range of values in terms of life decision-making. Again, we will not be expressing those today, but it is important that we are aware that people come from all walks of life and have their own views. Today we are going to concentrate, as I say, on the medical program.

Throughout the four-year postgraduate medical program at UWA our students are taught the principles of patient autonomy and informed consent, and that is throughout the period of their training. They learn about risks and benefits of everything that we do as doctors and they will do once they graduate from the program. Of particular interest today will be the teaching and learning that our students gain in palliative care. They have one discrete week of palliative care training

where they have a series of didactic presentations, as well as other aspects of learning, followed by clinical placements. This was introduced in 2001. In addition to that dedicated one week devoted to palliative care, the learnings of palliative care are undertaken throughout other aspects of their program, particularly, by way of example, in their general practice exposure, geriatrics, oncology, surgery, emergency medicine—in fact, probably in all aspects of their medical training.

In the palliative care program in particular, they will have face-to-face teaching with lectures and seminars, learning from specific cases that are presented to them in which they will interact. They learn about advance care planning, responding to patient's requests for withdrawing or withholding potentially life-prolonging treatment in the setting of poor quality of life. The students learn about communication and consultation skills and having the difficult conversation. In the practical placement in the palliative care setting, they have four days dedicated to clinical placement in that area where they interact together with patients and carers in that placement. They gain knowledge and understanding of the law and ethics as relevant to medical practice and particularly this aspect of palliative care and end-of-life issues. During this education, they learn about control of symptoms; relief of suffering; as I mentioned, end-of-life issues; care of the patient within the medico-legal framework; and risks and benefits, as I said, throughout all aspects of their medical training, because it is important for all components of patient care. They learn about patient consent and autonomy and advance health directives. All of this is really foundational knowledge that the student needs to acquire from and demonstrate in their learning before they can qualify—graduate from our university and then become a qualified medical practitioner. We do not expect them on the day of graduation to be able to practise all of these, but they have a foundation knowledge upon which they will build.

These were the issues that we highlighted in our written submission and Professor Auret and I will be happy to take any specific questions you may have in relation to them.

[12.20 pm]

The CHAIR: Thank you. Could you tell me how long is the UWA undergraduate medicine program?

Prof. ERBER: The medical program moved to a graduate program, with the first students entering in 2014. It is a four-year program and all students are graduates on entry. Their initial degree can be in anything; it does not have to be in any of the medical sciences. So, it is a four-year postgraduate program.

The CHAIR: And it is one week within that four-year program?

Prof. ERBER: One dedicated week in palliative care with a demonstrated curriculum, which we could provide if you want that.

The CHAIR: Yes, that would be very useful, thank you.

Hon ROBIN CHAPPLE: I missed the answer to that question.

The CHAIR: It is a four-year graduate program and one week of palliative care.

Hon ROBIN CHAPPLE: Do you have course notes for that one week of training?

Prof. ERBER: That can be provided.

Hon ROBIN CHAPPLE: I think that might be very useful, if we may, thank you very much indeed.

The CHAIR: As part of that training, are doctors trained specifically in the doctrine of double effect?

Prof. AURET: There are several places where we might potentially talk about the doctrine of double effect. The first one is in general practice units in our preclinical years when the students introduced to case-based learning where these sorts of issues might be coming up, so particularly around

consideration of withdrawal of active treatment, initiation of treatment and end-of-life advance care planning, and then in our palliative care attachment, which is in the final year of this four-year course and very clinically based. In neither of these programs do we purposely teach the doctrine of double effect. There are several reasons for that. We do at all times, in every teaching scenario where it is relevant, teach our students about the medical ethics and the legal framework in which they practise. To some extent the doctrine of double effect has become less useful in our teaching because what we are trying to demonstrate is that a lot of the decisions that doctors need to make in all settings have both risks and benefits. For example, in the oncology setting they will be learning that the chemotherapy that is being prescribed, that they hope will either slow down or cure a cancer, has a significant one to two per cent risk of mortality or significant morbidity with that treatment. So, philosophically our faculty approaches every potential medical interaction as having both risks and benefits. If you like, in the simplest form, every time a patient and a doctor are making a decision, our students are aware that there is a doctrine of double effect in that. We are hoping for the good outcomes, our intentions are for the good outcomes, but there is a predictable risk, whether that is side effects, or whether it is an unpredictable risk such as an allergic reaction or something like that. We tend not to be very specific with the students saying, "This is the doctrine of double effect and it is very relevant end-of-life care." We do not teach that, but we do teach them, I guess, the ethical underpinnings that the doctrine of double effect was trying to describe across the whole curriculum.

In terms of the doctrine of double effect, I think people are particularly interested in it in terms of what do we teach the students about terminal sedation; I think that is often where it comes up. We formally teach them what palliative care is and what the faculty considers good medical practice—that would be completely aligned with most of the peak bodies in palliative care and the Australian Medical Association—which is that we would consider the withdrawal of treatment at the end of life if it is considered futile, supporting a patient not to undertake active treatment or even hydration or nutrition if that is against their wishes at end of life, the proportional use of any medication to alleviate suffering or, at times, the use of terminal sedation for unrelievable suffering. All of those we teach our students to be good medical practice, normal palliative care, completely within the moral framework that we practice as doctors and completely within the legal framework that our state has provided us. That is what we teach them. We define palliative care. We define good medical practice. We define terminal sedation. We talk a lot about proportionality. We talk a lot about consent. We talk a lot about autonomy. We reflect on cases such as the Rossiter case. We reflect on our laws, both those that protect doctors from outcomes—death in a patient if they support a patient in withdrawing treatment or not starting potentially life-prolonging treatment. It is a long way of saying no, we do not sit down with the students and specifically teach them about the doctrine of double effect, but they are learning that ethical framework throughout the course. We spend a lot of time talking to them about terminal sedation, palliative care and end-of-life management within the framework of good medical practice and within the framework of the law.

The CHAIR: You said that you define terminal sedation. One of the things that we have experienced is that there are a lot of different understanding of what that is. Can you give us your definition of terminal sedation?

Prof. AURET: Sure. Interestingly, we also have one of our student's—we went and got their notes and double-checked what they are learning as well as what we think we are teaching. Our definition of terminal sedation really is from two words—terminal, meaning end-of-life, with the expectation that the person will die during this, and the aim being to render enough sedation that the person is comfortable. We do highlight with the students that that is a proportional thing. We talk to them specifically about trying to use the lowest possible dose to render the patient comfortable. In

practice, for patients who have severe suffering, the students are made aware that that may require unconsciousness, but that that is a proportional medical response to the degree of suffering. What they will see in their attachments is that the team will spend a lot of time talking with that patient and the family and amongst themselves, reflecting on the suffering, trying to understand that and seeing if there is any other way that suffering can be alleviated. That idea of proportionality is very firmly within our definition that we teach the students of terminal sedation. In the end they do understand that unconsciousness may be the aim and that the person will die during that period of unconsciousness.

The CHAIR: Is double effect a relevant principle in terminal sedation?

Prof. AURET: It sort of goes back to my previous answer that those would not be the words that we would be using with the students. We would be explaining that this is acceptable, moral and legal medical practice and we would be highlighting the proportionality and the intent. In a lot of ways, someone else would describe that as the doctrine of double effect. Why do we not describe it quite that way? I think often because it ends up tripping students up in terms of that idea of outcome and intent, where what they are seeing in clinical practice is that the decision might not be as difficult as it sometimes appears when it is presented as an isolated ethical dilemma in a completely arbitrary created case. When the patient is in front of them and they can see and hear the suffering, when they understand how our system might respond to alleviating that and when they understand that sedation, for example, might be one of the tools, we concentrate on the intent and the outcome quite entwined rather than saying, "We're just going for this. It doesn't matter about that." We do not highlight the intent and tell the students not to care about the outcome. They are entwined.

[12.30 pm]

Mr J.E. McGRATH: Before we start drilling down into some of these issues that obviously members of the committee would like to discuss, I am interested in your submission. You talked about the faculty teaching the students —

... to develop their professional roles as advocates for the best possible care of patients at all stages of life. We offer a deep grounding in ethical practice and facilitate open discussion about the role of euthanasia and physician-assisted death.

You mention the word "euthanasia". I just wonder when euthanasia was first brought into the university's curriculum for medical students. Did this happen 20 years ago or 15 years ago? We understand this is a new phenomenon and it has been talked about a lot, but when did the university decide that this may be something that our students have to understand that they could be confronted with?

Prof. ERBER: As I mentioned, the program in palliative care was introduced in 2001 and was then further modified with the introduction of the doctor of medicine program, which commenced in 2014. We think it is very important that students are exposed to all aspects of health from conception to death. I think they also need to have an understanding of the terminology that is used in lay parlance, as well as in medical terminology. We do not teach our students about euthanasia, but they need to know what it is and, when the public are speaking of it, what it means to the public and patients so that our students have an understanding. But it is then in the context of the whole of the medical practice—risks and benefits in care and palliative care, as we have been discussing. I will see if Kirsten wishes to add to that.

Prof. AURET: I can reflect. I graduated medicine in the old program in 1993, and discussions about euthanasia were part of my second-year curriculum at that point in time. I think the original discussions about euthanasia have been around for thousands of years, coming out of the Greek

philosophical approach to trying to understand the meaning of life. Our medical writings have included thinking about what is right and wrong in medical practice, and what is right and wrong at end of life, for generations. Reflecting on the old textbooks that are in our bookshelves and in our own libraries, this has been a kind of core idea to introduce our students to for a long time because it is part of the ethical framework that we teach them about autonomy and about trying to do the best we can for the patient, to try to do the least harm and to act with justice. We kind of have had those as our core principles for a long time. The euthanasia discussion presses students to think about how do these ethical values play out if you have a patient in front of you who is suffering to the point where they want to talk about euthanasia.

Hon NICK GOIRAN: We were talking about terminal sedation there, and I am interested to know if you have any information about the prevalence of terminal sedation in medical practice in our state?

Prof. ERBER: I think that is beyond the remit of what we can address here. We really can concentrate on the education we are providing to our students. I do not think it is appropriate for us to comment on the prevalence of practice in the community.

Hon NICK GOIRAN: There is no research unit within the university that you might be able to direct us to who might have that information?

Prof. ERBER: I am not aware of anyone within the faculty who is undertaking research in that area, but Kirsten may have other information.

Prof. AURET: The main drive of academic research in palliative care within our faculty is more on advance care planning. We have no-one doing that work. There has been some audit work come out of our faculty, looking at what is happening on the ground in small series. But your best information would probably come from the Cancer and Palliative Care Network at the health department of Western Australia, because they do audit the use of end-of-life care pathways.

Hon ROBIN CHAPPLE: We have heard of—I think we are struggling with this—palliative sedation. Is that the same as terminal sedation?

Prof. AURET: I think I can really understand why you struggle with that, because I think really we all do. Even what we might mean by voluntary assisted dying or euthanasia or, for example, the term “passive euthanasia”—people’s understandings of, say, passive euthanasia and what we would call good natural practice because you allow natural death—there is a lot of confusion in these terms. I would think of them as relatively the same, so I probably would say we teach the term “terminal sedation” to the students rather than “palliative sedation”. If we just look at what we have written in our guidebooks, if we look at what the students have documented in their lecture notes, that is more the term that we would use. But I think that if they went to textbooks and, say, the *Oxford Textbook of Palliative Medicine*, you will find that across countries even, quite how these terms are written about will vary slightly. But I guess there is a common understanding that we are more than likely talking about the same thing at a doctor perspective.

The CHAIR: I have not heard the phrase “passive euthanasia”. Can you describe to me what that is?

Prof. AURET: This was old teaching, which we do not teach the medical students so much anymore, other than just helping them with the language. We do not say that this is a real thing. Passive euthanasia was a term that referred to the withdrawal of active treatment or the withholding of potentially life-prolonging treatment. That was called passive euthanasia

Hon Dr SALLY TALBOT: And contrasted with active euthanasia, which was an intervention.

Prof. AURET: Yes.

Hon ROBIN CHAPPLE: So a patient not wanting to have a PEG in or something like that would be —

Prof. AURET: In old terminology, that may have been called passive euthanasia, allowing that to happen, where now we would call that good medical practice.

The CHAIR: That leads me to my next question. In light of the Rossiter–Brightwater case, does UWA train junior doctors that competent patients may refuse life-sustaining treatment around the end of life?

Prof. AURET: Absolutely.

The CHAIR: Do they ever express concern about this?

Prof. AURET: No, they do not express any concerns about competent patients refusing life-sustaining treatments. The concerns that have been voiced by both our academics and our students are around how difficult it can be at times to assess competency in making very complex decisions in medically unwell patients, particularly those with delirium, dementia and neurodegenerative diseases. The issue of discomfort for our students is not the withholding or withdrawing or refusing of life-prolonging treatment; it is the issue of capacity and how do they do that safely and effectively.

The CHAIR: Does UWA train the students in capacity assessment?

Prof. ERBER: There is training in that regard. It is a complex area and it is undertaken in a number of components of the medical program, so it is not in the palliative care area. We have a geriatrics block that all students have to undertake and it is taught there, but it is a complex area.

Prof. AURET: Just to add to that, from a curriculum point of view, we are trying to provide the students at the point of graduation with the framework of how they might approach or think about a capacity assessment. But in practice, these are highly complex matters that we would expect our junior doctors to be referring to more senior colleagues, and often second opinions are required from psychiatry or geriatric medicine in a generalist context.

Hon Dr SALLY TALBOT: I notice that you have actually listed that under your areas for improvement—improving education in capacity assessment in patients with diminished cognitive capacity. It is not really a question; it is more of a comment. What we are hearing anecdotally is that the lawyers are just as confused as the medical professionals, so it may be an area where you have to work with your colleagues across another faculty to get them working together, because what we are hearing is that sometimes people are batted from one professional to another when they are trying to do the right thing and complete the AHD form with all the option sections to say they have consulted professional advice.

Mr R.R. WHITBY: If I could just add, we have had evidence from others that suggests—it is their contention—that for GPs and even a range of specialists, there is not enough palliative care education for young doctors and that more would be good.

Prof. ERBER: Thank you for that feedback. As I mentioned, when a student graduates from our university, it shows that they have met the learning outcomes, and they have been set in place based on the requirements of the Australian Medical Council—so, our accrediting body. There is always more that students could learn, and I would contend that every area of medicine would be, in fact, making the same claim.

We are not stating that students know everything about every field of medicine upon graduation, but they do have sufficient knowledge for them to embark on practice in their pre-registration year to then gain registration as a medical practitioner. But I certainly take the point that more could be taught. It then becomes a question of how long is the degree program.

[12.40 pm]

Hon Dr SALLY TALBOT: We are turning specifically to the subject of capacity assessment. You are not training specialists, are you? You are taking people through their basic medical qualifications even though they are now postgraduates?

Prof. ERBER: Yes.

Hon Dr SALLY TALBOT: In terms of it being one of your identified areas of improvement, should GPs be able to do an assessment of full legal capacity?

Prof. ERBER: I do not think that is for us to respond to. I appreciate the issue and the significance of it. Because we are training medical students to become medical practitioners, they then have to undergo more training, including to become a general practitioner, so I cannot comment on the training they receive upon completion of our degree and what would then give them the skills to be able to do that. I think that is beyond our remit.

Hon Dr SALLY TALBOT: It is an interesting question, is it not? I wonder whether you could tell us where we might go to find somebody who is comfortable answering that question? My question is based on the observation the committee has made that to do an AHD, you just have to have a medical practitioner say that you have full legal competence. To get an abortion, for example, you only have to consult a medical practitioner, yet we have a range of people who are now telling us that would not do for voluntary assisted dying. People must have an assessment by a specialist. Should we be talking to the people who are training your GPs?

Prof. ERBER: The general practitioner training is undertaken by the Royal Australian College of General Practitioners. They have, just like us, a framework and again, their program needs to be accredited by the Australian Medical Council, as does the training for any specialty training. I am including general practice as an area of specialisation within medicine. My recommendation would be for them to be approached about what are the learning outcomes that are required for somebody to become a GP and then undertake that.

Prof. AURET: There are learning outcomes documented in the general practice specialist curriculum around palliative care and end of life. The other curriculum that you might be interested in looking at is the postgraduate council, which supervises the learning and the accreditation of placements for our junior doctors. So when we finish with them, they then move into the health department system as interns, which is pre-registration, and then junior doctors. Before they enter a training program such as to be a general practitioner or a specialist physician or surgeon, there is actually a curriculum covering those years, too. That is available from the postgraduate medical council and I believe Dr Richard Tarala is the head. It does provide a framework for those doctors that are moving from being a medical student towards that next, very directed phase of their training when they are still trying to gather a broad experience in caring for people across disciplines. Again, there are items addressing end-of-life care in that curriculum, although I do not know it very well.

Hon ROBIN CHAPPLE: Dr Auret, you are a practising palliative care specialist—a double specialist. In what capacity do you work in that area, firstly? How many specialist practitioners are there? Is there another cohort of palliative care practitioners who are not specialists? How many are there? We are trying to get a bit of a handle on who is out there and who can provide these services.

Prof. AURET: I am a palliative care specialist and an academic. The university currently employs two dedicated palliative care academics, but we have had more in the past. Those academics are across the Rural Clinical School of Western Australia, so I am based in Albany across the School of Medicine and also across the School of Surgery in the past. There are students doing masters and PhDs in palliative care within our faculty, looking at different topics not necessarily around end-of-life decision-making, but other aspects of palliative care. Palliative care practitioners tend to be of two

main sorts. They can be fellows of the Royal Australasian College of Physicians, so they come with a physician-specialist background, starting the same sort of program as someone who might end up being a cardiologist or an endocrinologist or anything else. Then they divert into three years of post-exam subspecialty training in palliative medicine. At the end of that time, they are considered a specialist in palliative medicine. There are two practising rurally in Western Australia: myself and Dr Carolyn Masarei, who is in Bunbury. The rest are practising in the metropolitan area, but most contribute to some form of outreach to rural areas, either funded through the health department or funded through Outreach in the Outback, coordinated by Rural Health West and funded by the commonwealth. In terms of more coming along, there is a formal training program with quite a number of trainees. The coordinator of training at the moment in WA I think is Dr Anil Tandon, who is a palliative care specialist at Sir Charles Gairdner Hospital. He would have more information about the number of trainees and where they are.

The other main group of practitioners that deliver more expert palliative care come from general practice in the main and have a diploma of palliative medicine, again through the Royal Australasian College of Physicians. It is a six month, full-time diploma and it allows that practitioner—who is usually, as I say, a GP, but they can come from anaesthetics or other disciplines—a deep clinical placement in palliative medicine with the curriculum and with learning objectives that they have to achieve. They are not seen as specialists; for example, under Medicare they would not bill as specialists, they would still bill as their primary discipline—general practice—but they have a particular skill set.

The third group have no formal postgraduate qualification in palliative medicine, but have long experience. For example, in the metropolitan area a number of doctors work in the Silver Chain Hospice Care Service who may not have a formal postgraduate qualification in palliative medicine but have worked in that field for a long time and carry an expert skill set on the basis of their practice.

Hon ROBIN CHAPPLE: Thank you for that. It was really, really useful. Can you extrapolate how many people are out there in those three categories actually providing service at the moment? I am not looking for hard and fast figures.

Prof. AURET: I really would not be able to provide you good figures. I can direct you to the WA palliative specialist group. I am sure if you contacted Dr Anil Tandon, he coordinates that group. They meet monthly. I videoconference in; it is very hard to tell how many of them are in the room. They also know the number of trainees. The other way to find out how many people are practising, for example with the Silver Chain Hospice Care Service would be to contact their medical director, who I believe is Dr Sarah Pickstock at the Silver Chain Hospice Care Service. She will know exactly how many GPs are in their service practising with the skill. In terms of how many people are doing a diploma, I have a diploma candidate in the rural context at the moment, but I would not know how many more diploma candidates are currently sitting in Western Australia, but the college of physicians would know because they supervise the diploma.

Hon NICK GOIRAN: You mentioned that you are based in Albany. Would you be in a position to advise the committee of any places or facilities that would be useful for the committee to visit? It is on the public record that the committee is going to Albany next week and we would appreciate any advice you might have.

Prof. AURET: I believe that you are coming to the hospice, to the emergency department, and to speak with the regional palliative care service. I think you will get a very excellent overview of what is happening. I have been trying to facilitate access to patients and families, as well as staff and volunteers. The other major service providers of palliative care are obviously general practice and residential aged-care facilities. If there would be some capacity to meet with representatives from

general practice or to spend time at any of the residential aged-care facilities that provide so much of the palliative care for frail, elderly people in the regions, that would be another place to go.

Prof. ERBER: We have 10 medical students in the Rural Clinical School at Albany if you wanted exposure to students and what it is that they learn.

Prof. AURET: Because they are in their third of the four-year course and we take students from both Notre Dame and UWA—we are a combined school—not all the students would reflect the UWA curriculum. They are also one year prior to doing their intensives. They do their intensive in their final year. They could talk to you about what they are seeing on the ground; they could talk to you about their preclinical training, but they would not be able to talk to you about the palliative care intensive, which they would have in their year after returning. Just in terms of the opportunities provided to students, though, we do as well offer them electives. If we have students who have a particular interest in palliative care or end-of-life care, although the curriculum is so full, there is space given to students to pursue particular interests, and if someone has a particular interest in pursuing more study in palliative care, end-of-life decision-making and end-of-life management, they do have the capacity to do that, and again we have a senior medical student who is doing that with us at present, and that is a six-week extra attachment.

[12.50 pm]

Hon NICK GOIRAN: If I understand correctly, the one week intensive on palliative care is done in the final year.

Prof. AURET: Yes.

Hon NICK GOIRAN: And that is not applicable to this Albany cohort at the moment, because they are in their penultimate year. There would be a cohort in Perth that is in their final year. When are they scheduled to do the one-week intensive?

Prof. AURET: The dates for 2018—there will be two cohorts that have done the intensive so far, one starting on 12 February and one starting on 26 February. The next cohort is due to begin on 19 March.

Hon NICK GOIRAN: And that would be it for the year?

Prof. ERBER: No, the students go through rotations just like schoolkids in having a term, so the medical students also rotate. We have got 240 students and they cannot all do it at the one time. It is on rotation, and when they are in a particular block they will spend that one week, so it is an ongoing program.

Prof. AURET: We deliver that intensive 12 times over the course of the year, and we have significant support from our clinical colleagues at Bethesda, at Royal Perth, at Sir Charles Gairdner Hospital, at Fiona Stanley, at Armadale and Kalamunda and the Silver Chain hospice care service, so all the significant providers of clinical palliative care take the students for four days.

The CHAIR: Do you think there are enough palliative care specialists and GPs competent in this area to meet demand?

Prof. ERBER: From a university point of view, I do not think we are in a position to respond to that. I will leave it to whether Kirsten wishes to answer from a personal perspective. What I can say is that we have a lot of medical students now coming through the system in this state, and there is a bottleneck in the ability for medical students to go on into specialty training. There could be more students who, on completion, would like to go down this path, but at the moment it is actually very difficult for a number of them to get any specialty training.

Prof. AURET: I think, a bit like the answer to the previous question, in your own discipline you would always like to see more. I can reflect on close to 18 years as a palliative care specialist and three years training before that, and there have been remarkable improvements in what I see. I was reflecting that when I was a medical student I did see people screaming in pain on the wards. I do not see that anymore. I think our advances in symptom control have been remarkable. I think our ability to relieve all suffering has remained difficult, but our pain management skills and what we teach the students—the groundings we give them—means the baseline competency of even junior doctors in managing symptoms is much better than it was. The other thing that is much better than it was in terms of our junior doctors and students as they come out is their ability to describe to patients what palliative care is. I can reflect on the fact that when I used to go and see a patient with my palliative care hat on there would often be a lot of distress in the room before I even said anything, just because I was from palliative care. That initial distress is much less now, I think because our junior doctors are able to say to a patient, “I think you would benefit from palliative care, and this is what palliative care is”, and has a working definition that they feel comfortable explaining to the patient. Those are two very significant changes that I think have begun in medical school, so that the general crop of junior doctors has a level of competency that is better than it was before. There is always much that we can do, but the medical faculty is trying to provide a framework to begin practice. What we are talking about is highly skilled, complex, not just technical medicine, but ethical and communicating medicine. That is something we do not expect our students to take on as junior doctors; that is something that they will learn through their specialisation, whether that is in general practice or another discipline.

Prof. ERBER: If I can just add to that, Kirsten mentioned that she has been in this field for 18 years, plus three years of training, so let us say 20 years. I go back further than that. Palliative care was not in my medical program at all. There has been a huge change, and I think the care of patients has improved significantly through the introduction of the specialty of palliative care medicine, and I think we are alleviating suffering much better than ever before. I know that there was concern around the room—I could hear it and I could see it—that only one week of dedicated time is directed to palliative care, but that is a huge improvement, and our patients and our community have been the beneficiaries, and their families.

Prof. AURET: I think I would also like to reinforce that some of the content of palliative care is taught specifically in other disciplines. For example, general practice runs a number of teaching scenarios that are very much about palliative care. For the general practitioner, for example, one of the cases taught involves going into a nursing home where there is a frail elderly woman with severe dementia, recurrent pneumonia, currently being sent to hospital, lots of distress in the family about whether this sort of treatment should be continued or not, no advance health directive in place, and no surrogate decision-making—how would you handle that? That is taught in general practice, so it is not included in that week. Equally, in another case taught in general practice, a man comes in, does not want to die, with conflict in the family, does not want to have his life prolonged, and wants to do an advance health directive. So in general practice students are taught how to have that conversation and what the forms look like. They have a go at filling in the treatment decisions and circumstances, then they are taught about what makes this a legal document. Again, that is sitting in general practice. A lot of the pain management will be sitting in anaesthetics and pain, which is a separate week. A lot of the prognostication around severe illness would be sitting in, for example, respiratory medicine, with end-stage COPD, or how to manage someone dying of metastatic disease might be managed in oncology. It is not just that that is where it is dealt with, but this is a particular intensive.

Mr J.E. McGRATH: Professor Erber, I would just like to take you back to the comment you made about the bottleneck for specialty training. This is something that was raised with us by the AMA, and I know it has been around. It was raised when Curtin wanted to have a school of medicine, so it has been a moot point. What causes this bottleneck, and what could government, either commonwealth or state, do to alleviate it, and get more people into that specialty field when they graduate?

Prof. ERBER: Thank you for the question. This is a really important issue. It is important for our graduating medical students and it is important for our community. If I knew the answer, I would give it to you. I think what we really need is more places accredited by our royal colleges to undertake training in whichever area, be it orthopaedics, endocrinology, or my area of haematology. We need the colleges to accredit more positions so our junior doctors have the ability to take up training and pass the examinations so that they can then become specialists, or specialist generalists in general practice. It is a national issue; it is really important. If we are unable to address this problem, this state—every state—will have the problem of having junior doctors who do not in fact have the skills or the recognition to be able to practice in really any area. They will be restricted to practice within hospital, without being able to go out and serve the community in any other way. I am not sure if that answers your question.

Mr J.E. McGRATH: So is this a funding issue? Why are they not making more positions?

Prof. ERBER: No, it is not a funding issue. It is the royal colleges that accredit the positions as being recognised for training. It is the state which then provides the salaries for those positions. We do have some people, for example, in dermatology—skin medicine—we will have some doctors working in the dermatology area, in the outpatient clinic within a hospital. They want to become a dermatologist, but the job they are doing, the position they hold, has not been accredited by the royal college. It is the same in orthopaedics or whichever area of medicine. I am not picking on dermatology; it is quite a universal problem. It also occurs for general practice and in the sustainable health review interim report that has just come out, 974 positions are required for general practice training. It is a really important, very big issue. It is not all about money. The royal colleges have a big role to play and I think we need the commonwealth to deal with this as an issue.

[1.00 pm]

Hon ROBIN CHAPPLE: Just on that, you have actually got somebody who is leading with dermatology, somebody who is practicing dermatology, and doing a really good job, who could almost go out and function outside the hospital but just cannot get the accreditation?

Prof. ERBER: And you need to be in an accredited position and undergo the accredited training program which has certain landmarks and may include examinations—not all colleges have examinations—but you need to go through the structured training program of that college as recognised by the AMC to acquire the fellowship of that college. They may in fact have a lot of the knowledge before they embark on the accredited training program.

Hon ROBIN CHAPPLE: It is not really our remit here, but I am really interested in this. What drives the medical profession not to provide those accreditations?

Prof. ERBER: I have a personal view on that but it is probably not appropriate for me to express it here.

Hon COLIN HOLT: You said palliative care from GPs is a really complex field due to some technical, communication and some of the ethical questions and often, this is my words, it is more difficult for junior doctors. I would say—and correct me if I am wrong—many junior doctors get sent in their early years of practice into regional areas, often single doctor in a single town attached to a hospital

or an aged-care facility. Can you make any comments around the support that they get in terms of palliative care in their local communities and what can we do to improve that?

Prof. AURET: I can talk from the perspective of the Rural Clinical School of Western Australia. That is a school within the faculty of medicine and we are obviously across universities. We also have students from Notre Dame. As part of our remit we are funded by the commonwealth to look at the question of what is happening in regional training. We have expanded our role from just students to looking at postgraduate medical education. The first thing is that WACHS has now become a primary allocation centre, which means that preregistration doctors—interns—can be employed for the full year of that preregistration in a WACHS site. That is new. Before, they would be sent from the primary allocation centre in the city to a regional location. However, they cannot go to those locations unsupervised. They have to go into an accredited position, accredited by the Postgraduate Medical Council, which is part of the health department of Western Australia. What is looked at with those positions is exactly what you are commenting on. The degree of supervision and safety around that person as a practitioner and in terms of the patients they are servicing. Because they are junior, they need to be adequately supervised. There is a lot of security to say that if a junior doctor is employed in WACHS, they will only be in the job where the supervision has been scrutinised, which sometimes limits where people can go and limits the capacity of regional communities to access even the benefit of a junior doctor, because that senior supervision is not there. That is a model that we are really looking at very closely in the Royal Clinical School. Separate to that, when people enter general practice training as a GP registrar—they are training now to become a specialist in general practice—they may be sent out to small towns. They will always have a supervisor and usually that supervisor is present. Sometimes that supervisor may not be Australian trained. Obviously, a lot of our regional communities are serviced by overseas-trained doctors. There are sometimes concerns about the quality of supervision given to training doctors sent to small towns. That is an area that is being looked at. There are a number of models that are exploring that. As you may know, the college of general practitioners has been tasked by the commonwealth to take back oversight of general practice training across Australia where it has been tendered out to other bodies. For example, in Western Australia it is WAGPET, WAGP education and training; ACRRM, the Australian College of Rural and Remote Medicine; and the other main training provider is actually out of Victoria, which is the regional and remote training scheme, a remote supervision model trying to address the concerns you have. Within that GP training, even if they are rural, they will have a curriculum. They will have a supervisor that may have been trained in the Australian context about palliative care or perhaps not. In terms of backup throughout the state, the Department of Health does fund a 24-hour number where any GP, GP registrar, junior doctor or nurse can phone up that number and talk to a specialist consultant in palliative care any time. I am on that roster and we do get calls from places where they are very isolated. I think they get a lot of support from that number in terms of the complexities of decision-making, prescribing and the ethical dilemma they may not have even seen, and to have that discussion with a senior colleague that is available even when someone is solitary and remote, as long as they have got a phone line.

Mr R.R. WHITBY: My question might be a bit redundant now, because I really wanted to ask Professor Erber about what the motivation might be at the royal colleges.

Hon ROBIN CHAPPLE: Try again, please!

Mr R.R. WHITBY: How about I try this much at least: Is the roadblock, the issue, with the royal colleges? Is that where the problem is?

Prof. ERBER: I believe so, because they are the ones that will determine whether a registrar position—somebody who is about three or four years post-qualification as a doctor who spent two

or three years working in a hospital system—can then embark on a specialty training program. The position that they take must be accredited by the relevant royal college to then be embarking on their program of training. Yes, they do control the numbers.

Mr R.R. WHITBY: You are saying that those young doctors will be doing that work anyway and being funded by the state? The money is already being spent?

Prof. ERBER: Yes, it is state money, apart from a small number of positions across the country that are funded by the commonwealth, particularly for positions in rural areas. If we had the ability to train a psychiatrist, for example, in Albany in a position that had been accredited by the college, the commonwealth may then fund that position whereas normally these training positions are funded by the state.

Mr R.R. WHITBY: But in any case, you are not saying it is a money issue, it is an accreditation of a position issue?

Prof. ERBER: Money is a separate issue but the main block here is in fact the accreditation of positions by the colleges.

Hon Dr SALLY TALBOT: I wondered whether you could just help us clear up what I suspect might be a bit of confused terminology. I am going back to the issue of assessment of capacity. When we talk to the witnesses who are keen to see GPs not given the authority to do that capacity assessment, the language they use is that these people, in order to complete a VAD application, you need to be assessed by a specialist. They talk about psychiatrists, gerontologists and palliative care specialists. From what you have told us, GPs themselves are specialists. They are specialists in general practice. Have I understood that correctly?

Prof. ERBER: You have.

Prof. AURET: Yes, that is correct.

Hon Dr SALLY TALBOT: When a student doctor leaves you, they have got their postgraduate qualification and they are going to a hospital to do their internship, does every doctor then choose a speciality to go into? Or do some choose not to specialise?

Prof. ERBER: The majority will choose to undertake some specialty training which may be general practice.

Hon Dr SALLY TALBOT: It may be general practice. Okay. Do we have any GPs in WA who are not specialist general practitioners?

[1.10 pm]

Prof. ERBER: It is probably best not for me to answer. What I can say is that we do have medical graduates who have come from overseas who are working as general practitioners who are not fellows of our college of GPs. How many locally qualified, domestic medically-qualified doctors are working as general practitioners in our community who are not fellows of the college, I cannot answer.

Hon Dr SALLY TALBOT: So you could apply for a job as a GP without having specialist qualifications?

Prof. ERBER: As a registered medical practitioner, is there any bar on you working as a general practitioner, I cannot comment; I will not comment.

Hon Dr SALLY TALBOT: So we will go to the college for that information?

Prof. ERBER: I think that would be preferable.

Prof. AURET: I think the other place to go is to the federal health department, because a lot of the rules about where you can work are completely bound by your provider number, and your provider number allows you to access Medicare. If you do not have the appropriate qualification, you cannot access a provider number, in which case you cannot access Medicare.

The CHAIR: I am just going to go back to some of the legal frameworks. We have had some evidence that some practitioners are uncomfortable about refusal of treatment. Do you think that doctors in WA are aware of the legal protections in the Criminal Code in relation to refusal of medical treatment per an advance health directive?

Prof. ERBER: I will start with the answer and then I will hand over to Kirsten. One of the things that we do teach our students is about the medico-legal framework in which they will be working upon graduation. It is learning to which they have been exposed, teaching we have given them during their medical program, so when they leave us we know that they have had that understanding.

Prof. AURET: I would agree with that. They are specifically taught that this is the legal framework in which they are practising.

The CHAIR: Given that there is some evidence that there is some level of discomfort over it, do you think that is a legal discomfort or an ethical and moral discomfort?

Prof. AURET: I can tell you how we frame our teaching. Our teaching is that there is an expectation that there may well be a moral or religious or a non-legal discomfort in our students. That discussion is explicitly encouraged. We do encourage our students to reflect on what a good death means to them, what a bad death means to them, what elements of the care of dying patients make them uncomfortable and where that might be coming from. So they are assisted in some self-reflection both in the early general practice years, in the palliative care attachment, and through formal writing that they have to do, where they do reflections on their own attitudes, behaviours and the ethical framework that they are practising from. We do provide the students some space to think about not just this is the law, but what are you bringing, and how will that impact on your patients. That is very clearly part of our teaching.

The CHAIR: Does the school teach the students about what would constitute a reportable death under the Coroners Act?

Prof. ERBER: I might hand over to Kirsten to respond to that.

Prof. AURET: So if I am allowed to say yes and no. We do teach the students about death certificates and reportable deaths in a number of places. For example, in the emergency department curriculum, that is discussed, and they will obviously see that in their clinical attachments all the time. In their surgical attachments, they will see mortality after surgery and they will be part of the clinical team, both sitting beside the doctors doing the death certificate, or part of morbidity and mortality meetings et cetera. Separately to that, they have formal teaching in what they need to be able to do by the health department. Exactly what they need to do for death certificates, what they need to write, is formally taught to them by the health department in their pre-internship. They normally have about a week of training. The actual curriculum and the lecture that they get delivered in that regard will be available from the health department, and it is delivered at their hospitals before they start working.

The CHAIR: In the palliative care speciality, in that training, is there more detailed training on what would be a reportable death? I am looking at really instances of refusal of treatment, voluntary starvation, terminal sedation, for example?

Prof. AURET: What we teach the students in that intensive is that the patient died of the underlying disease. We do not teach them that the patient died of terminal sedation as the cause. They died of

their metastatic malignancy or their end-stage respiratory failure. That is what we teach the students.

The CHAIR: The treatment, rather than the cause?

Prof. AURET: Yes, the treatment, not the cause.

Prof. ERBER: It is taught throughout the medical program that the cause of death is the underlying disease. Complications of treatment do occur, be it in oncology and death from infection, but they in fact died from the underlying cancer, and that is what they are taught. In the final phase of the medical program before graduation, the students do a rotation called preparation for internship, where they are working on the wards, in effect with the health delivery team, and they will be exposed to some of this from dying patients within the hospital setting. As Kirsten mentioned, in their one week of orientation, really graduation from being a student to being a junior doctor, the health department gives them the formal education on completion of the death certificate.

The CHAIR: In relation to voluntary assisted dying, does the faculty endorse and teach the principle of patient autonomy?

Prof. ERBER: Yes.

The CHAIR: If VAD were introduced in Western Australia, would the faculty provide undergraduate doctors with training in this area?

Prof. ERBER: The faculty would be providing information about the medico-legal framework in which they work, so they would be informed of the law in this regard.

Hon NICK GOIRAN: Does the faculty endorse and teach the principle of informed consent?

Prof. ERBER: Yes.

Hon NICK GOIRAN: Does informed consent require capacity?

Prof. ERBER: Yes.

Hon NICK GOIRAN: And the absence of duress and undue influence?

Prof. ERBER: Yes.

The CHAIR: Do you have a view of whether VAD legislation should contain any specific protections for patients and doctors?

Prof. AURET: In preparing for the submission, I spent a lot of time talking with clinicians who deliver our teaching. I think as individuals, and as you would have heard from, I imagine, a number of submissions, people do have strong views on whether voluntary assisted dying legislation is required and is ethical; and, if it is required, what safeguards, and what would the legislation look like. But, really, there is not a faculty position on that to then allow us to say we are of the same mind to say if this is what happens, this is the way it needs to look. In this we would come back to saying that we will practise and teach our students within the framework of the law that is created by the government. So really I guess our position is that like all the teaching that we give the students, the protection around patients, their safety, the quality of the care we give them, will be paramount, and whether that is talking about how we teach them about voluntary assisted dying, should it become legal, or whether it is teaching them about how to consent to a patient for an appendix removal, I think the framework that we teach our students will remain—the desire for the best quality care of patients and keeping patients safe within our health system will remain. I think our faculty relies on the counsel of the community and the government and the society to which we belong to give us the framework in which we will practice.

Prof. ERBER: We will be ensuring that our students have the foundational knowledge so that they will then be able to become medical practitioners. We are not going to influence their views. We are giving them that framework so they understand autonomy, consent, capacity and the legal framework in which we all work as medical practitioners.

Prof. AURET: The other thing I do want to say is it is very unlikely that the students would receive any training in how to do voluntary assisted dying, because that would not be seen as a core competency at a medical student level. That would be an advanced skill that would be within the domain of the specialist training. It would not be something that we would ever be planning to put in the junior doctor curriculum, any more than we would teach them to do a caesarean section.

[1.20 pm]

The CHAIR: Advance care planning: we have received a lot of evidence from both the medical community and the general community that people still do not fully understand formal advance care planning, in particular, advance health care directives and EPGs. I think you said you would touch on this area in your training. Would you say it is comprehensive or could it be built on?

Prof. ERBER: It is certainly included in the training program. I have student notes in front of me showing evidence that they were exposed to that learning during their palliative care attachment. Again, Kirsten is intimately involved with this.

Prof. AURET: All I can say is that I think they are being introduced to a framework and being made familiar with what the paperwork looks like and the sections of the paperwork. The complexity of filling in an advance health directive or nominating a surrogate decision-maker is I think as much about the conversation as the paperwork. The conversation is a more highly complex skill and that comes with experience as a doctor and training as someone progresses through their post-graduation training.

The CHAIR: Do you think there could be better post-graduation training on this?

Prof. ERBER: I do not think we should be commenting on that. There are many people out there who would be involved with the requirements, largely within the general practice community but geriatricians, palliative care physicians, a lot of other people. So I do not think it is for us to respond.

The CHAIR: There seems to be a view emerging from the medical community and health care, not all but certainly a large proportion, that they prefer health care plans rather than the legally binding advance health directives. Do you have a view as to why that might be?

Prof. ERBER: Not from a university level.

Hon ROBIN CHAPPLE: When it comes to the DNR, do not resuscitate—it has been my perennial question and that is why my colleagues find some humour in this—do you instruct or teach your students in relation to the application of the DNR requirements?

Prof. AURET: Not within the framework of the intensive in palliative care. I do have to say that the practice framework that our students are being exposed to in terms of the policies at the hospitals that they are working in and their clinical attachments is changing quite quickly. The kinds of forms that are being used to document do not resuscitate orders or, now, goals of care orders and the impact of advance health directives on the policy level at the hospitals these students are practising in is an evolving area. So our students are being exposed to evolving practice within the clinical teams and the hospitals that they are at, but it is not taught formally in their palliative care attachment.

Hon ROBIN CHAPPLE: What would you understand the processes around DNR to be if you were to try to explain it to a student? Is it something that the doctor initiates, the family initiates, the patient initiates? Do you have a view on that?

Prof. AURET: That is a good question. I do not know if I have spent time thinking about whether I have a view from a teacher perspective. I can say what we teach the students, whether it is about a do not resuscitate decision or any other decision in medical health, despite the fact that this is obviously such a life and death one, we teach them the principles of actively seeking the values and preferences of the patient, and including the patient's family in consultation with medical decision-making where appropriate. I suspect that the students would probably come to that do not resuscitate decision by asking: How would they communicate that? What framework would they use? I think they would use the same skills that we teach them for other interactions. They would use the same open questions. They would use the same skills that they have been taught about breaking bad news or eliciting difficult or sensitive information, sexual history et cetera, and they would try to sensitively and respectfully listen out for the patient's values and preferences. I think that is the framework that we teach the students and I think that is probably how they would approach it if they got asked. They would not be put in the situation of doing that while they were a medical student. It would be completely inappropriate.

Hon ROBIN CHAPPLE: That was the point I was wanting to get to.

The CHAIR: Thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor 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 your evidence 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 corrected transcript of evidence. The committee will write to you with questions taken on notice during the hearing. Thank you both very much for your appearance today.

Hearing concluded at 1.24 pm
