

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, 18 MAY 2018**

SESSION ONE

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 10.01 am**Dr OMAR KHORSHID****President, Australian Medical Association, examined:****Dr KATHARINE NOONAN****Policy, Research Lead, Australian Medical Association, examined:**

The CHAIR: Welcome back Dr Khorshid and Dr Noonan. Thank you very much for returning to give further evidence to the committee. I will read the opening statement and then we will start the hearing. 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 with us Mr Simon Millman, Hon Dr Sally Talbot, John McGrath, Mr Mathew Bates our principal research officer, Hon Colin Holt, Hon Nick Goiran and Hon Robin Chapple. The main reason for inviting you today is to provide an opportunity for you to inform the committee of the outcomes of the AMA symposium held on 5 May. 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 proceeding. I advise that the proceeding of the this hearing being 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 KHORSHID: No.

The CHAIR: As I said, we invited you back to provide evidence for the committee and to report back to us on your members' symposium on the end-of-life choices. I might hand over to you for a while, Dr Khorshid.

Dr KHORSHID: Thank you very much. I would like to thank the committee for inviting us back. We held what we believe it to be a very successful member-only symposium on 5 May looking at a range of end-of-life care issues, including the current state of palliative care and obviously the debate on euthanasia and physician-assisted suicide. The aim of our symposium was to really explore the current state of end-of-life care issues in Western Australia both geographically and within different specialties, and to get as much perspective as we could as an association from our colleagues at the coalface. We wanted to learn from experiences in other jurisdictions and we were very privileged to have some eminent visitors from other countries and also to be able to interview some others over Skype. We wanted to develop our own internal position and therefore advocacy on any potential legislation should the committee make that recommendation and should the Parliament go down that path. We wanted to position the AMA to be able to advocate appropriately in that space and really to give our members a say as a membership organisation on a very divisive issue, which, as we know with other divisive issues, if you pitch it wrong, you end up with a very acrimonious debate. We wanted to avoid that and to give members of different views the opportunity to be heard and to inform what we have to say in public and in this committee. What the symposium was not about was changing our overall position as a medical association. That policy—which we referred to last time and I am sure you have seen—is a federal AMA document and that was not up for discussion or debate. That was taken as read and accepted, and it does enjoy broad support throughout the medical profession with people of both views. The symposium

was also not a debate on the pros and cons of voluntary assisted dying. That was not the format. It was more about exploring the issues.

In terms of the international perspectives, we had some very eminent guests. We had Professor, the Baroness Ilora Finlay, from the UK who is co-chair of Living and Dying Well. She is a palliative care physician, a member of the House of Lords and very active internationally in this debate on promoting palliative care and ensuring that discussions around end-of-life care and euthanasia are evidence based. She was able to fly out here and present in front of the symposium and also participate in some panel debates. We also had Dr Gordon Gubitz who is a neurologist from Canada and a medical assistance in dying practitioner who was able to share his personal experience of delivering medical assistance in dying in Canada, and also make some general comments about how that was implemented in Canada. We had Professor Theo Boer who is an ethicist from the Netherlands and also prominent in the media and the medical press in commentary on euthanasia issues with extensive experience having participated in the review panels that they have in the Netherlands for a period of around about a decade. He was able to share with us his experiences and his changing perspectives on euthanasia going from cautious support for euthanasia to being a very strong sceptic and opponent of euthanasia through his experience in the Netherlands. We also heard from Dr Jeff Blackmer from the Canadian Medical Association and the World Medical Association who was heavily involved in the Canadian Medical Association's interaction with this debate when the Supreme Court required Canada to move forward in this direction. Obviously, the medical profession had to jump on board and he was able to share his perspectives on that. We had Professor Jocelyn Downie, a lawyer from Canada who was actively involved in the advocacy for access to euthanasia in Canada and did some of the pro bono work for the Supreme Court case that led to the ultimate outcome in Canada. I would like to share some of the learnings that we got from those people and from our general debate, and hopefully some of the questions that you have asked me will be covered as we go along.

Before I get onto the specifics, I want to make the comment that that international experience that we were able to share was really enlightening for us. To be able to see it in person and to be able to quiz the individuals was far more powerful than reading documents and even articles written by the same people. Certainly, one of the things that I would like to recommend to you is that you avail yourselves of that kind of opportunity of speaking directly with people who have experience in jurisdictions where there are very different models from very liberal in some of the European countries to very restricted in Oregon. Obviously, we have Victoria to learn from at some point as well as they go through this process. You can do what we did and call them into WA, and we were lucky to get a couple of them here, but the other option would be to visit those jurisdictions. Certainly, most other jurisdictions that have gone down this direction of having gone out on a roadshow and visited those locations.

In terms of the current state of end-of-life care there are a few very clear themes. The first was that there is a lot to be done in this area. It was very clear to us that we need to accept that the public is saying that their experiences of end-of-life are not what they should be. We are pleased that this debate, whilst it is difficult for the medical profession, has actually brought the topic of end-of-life care and palliative care right into the public domain. We accept that change is needed and the majority of that change needs to be in the areas of palliative care. The key themes are, of course, resources. Palliative care is limited in certain sectors. It is pretty good in cancer care. It is not good in rural areas and outer metropolitan areas, and that is simply a resourcing issue. Access to specialist palliative care physicians is only one part of the broader topic of palliative care, and we spent a bit of time on the fact that palliative care is a set of principles that actually needs to be properly integrated into all medical care—primary care, hospital care, cancer care and aged care. We heard

that there are gaps there. There are gaps in the training of medical professions, which I think I talked about last time, that really we as a society and as a medical profession need to fill. There was strong support from the symposium for moving in that direction. We heard commentary on the fact that it is difficult in primary care and even for some of the specialists—either in consultation areas and psychiatry or in palliative care—to deliver what they would consider to be good holistic care because of the models of how our medical is set up and the fact that we fund episodes of care. Whether it be in primary care or in hospitals, it is all about this little widget of activity which generates money and that is how you fund your model. In chronic disease generally and certainly in palliative care we need to be looking at different models that actually cover the patient's journey no matter whether they are interacting with primary care, hospice care, hospital care or whatever. That would promote the ability to spend the time on, for instance, advance health directives and advance care planning in general. We heard that it is difficult for families and doctors to find the time to have those discussions in our very high-pressure medical environment.

Another strong theme that came out was the need to promote end-of-life care discussions in families, which again we talked about last time. We really hope that this debate is used to generate positive discussions within families early while everyone maintains competence—while patients are able to make decisions and make their views clear to their families. Advance health directives are part of that but because they are rigid document set at a single point in time they are not the whole story, and the general topic of advance care planning and of goals of care discussions when patients enter a hospital environment are really important.

Another factor that came out was the communication issues that we have between our disparate parts of the health sector—our complex environment. We heard stories of patients in a palliative phase of their treatment and well organised in the community through general practice and Silver Chain and who, for whatever reason, on a weekend or after hours, were thrust into the hospital sector where they did not know what had been going on. They did not know what the goals were. The patient may not be able to communicate properly and, all of a sudden, the care is inappropriate; it is hospital-based and it is about curing and fixing problems and it is not in the patient's or the family's interest. We do not necessarily have the solutions for that, but obviously we need to be using technology to connect our health system better. Whilst we have different models of different sources of funding et cetera, we are always going to have some barriers, but technology can be used to break down those barriers and make sure that patients are able to communicate their wishes to all the different types of practitioners who are going to be treating them, including in emergency situations.

We then moved on to some of our international speakers, one of which was Theo Boer. He had some really cautionary messages for us, the first of which was a question that Dr Noonan put to him about the increasing numbers of patients accessing euthanasia in the Netherlands and whether that constituted a slippery slope. His perspective, having been at the coalface for 10 years reviewing cases, was that there had been a fourfold increase—he said fourfold; the official numbers probably say threefold, but there are unreported cases as well—or a substantial increase in the number of people accessing euthanasia as a result of cultural change.

[10.15 am]

He communicated to us that the expected demand was about 2 000 per year in the Netherlands and that is how it started and that is how it stayed for a period of time. Then from around, I think, 2007, there was a rapid increase in people accessing euthanasia as that, I guess, course of treatment or that option became acceptable for the treatment of a whole range of conditions, not just terminal conditions but chronic conditions, mental health conditions, disabilities, autism, blindness—

examples that, I guess, do pose a question as to where do people with these conditions stand in society if society says that suicide is a reasonable way to relieve the suffering associated with that condition. What message does that send to the people suffering from those conditions and also to the doctors and other medical professionals treating those conditions? He was very strong on that. He made a comment around the normalisation of suicide as an option and the increasing rate of suicide outside of euthanasia in the Netherlands compared with a similar jurisdiction being Germany that does not have euthanasia. He quoted us a figure of a 30 per cent rise in suicide over a certain period of time; I cannot remember the exact time. We have heard other numbers that are a bit smaller, but there certainly has been an increase in suicide in the Netherlands since euthanasia became accepted as a treatment.

The Canadian perspective was, of course, quite different, having been rushed in as a result of the Supreme Court decision. Even very strong proponents of euthanasia that we heard from accepted that they have not got their model right and they made a lot of mistakes. Some of that is around the legislation itself; some of it is around just not having the time to put processes and infrastructure and funding in place to support the services that are being required by the public. We heard in particular from Jocelyn Downie of the need to get right down into the nitty-gritty, right down into the details, into the exact words used in legislation, because words that seem obvious at first glance, when you actually implement them, can be very broad. The example that was given by Jocelyn Downie was “foreseeable death” and, of course, the one thing that is foreseeable for all of us is our death. But that is the definition in the Canadian legislation. Obviously, in Victoria they have said six months, but we know that that is very, very hard for us to prognosticate on as well.

The exact terminology used has a big impact on how it is implemented after the legislation is introduced. Obviously, safeguards are absolutely critical. Details such as what do you put on death certificates, how does it interact with coronial inquests, is it a natural death or unnatural death—there is a lot of impact of this sort of change on other aspects of how we deal with death and how we structure our society. Obviously, processes, infrastructure, funding and reporting—in both the Netherlands and Canada, they did not have a clear understanding of exactly how much euthanasia is going on because of unreported cases or, in the case of Canada, they do not really have a system to collect the data properly. They are moving in that direction; they realised they need to. We heard very strong suggestions from all those pro-euthanasia people that if you are going to go in this direction, you have to get those things in place first before you offer this service to the public.

The other messages from Canada were the need to train the professionals implementing any euthanasia structure properly. Again, we heard from Dr Gubitz who was somebody who felt he had the skills and attributes to deliver this care, being involved in death quite a bit and being a neurologist dealing with stroke care. But he gave his personal experience of having basically no training, and just having shown some interest, suddenly, he was thrust into a position where he was delivering that service in the community unpaid in people’s homes. We would strongly urge that not to occur in Western Australia. We need to be much more organised and obviously not having a Bill of Rights that brings that time pressure in helps us.

The other message from Canada was the need to avoid a divisive debate within the medical profession. It was a very strong message that they felt their medical association had grown and become more compassionate. He even made the comment—this is Jeff Blackmer—that it could have been the best thing the CMA had ever done by engaging properly in a debate on it, and that is certainly our intention at AMA WA.

So then onto the area that in the event euthanasia is legalised—so that was probably all the steps taken towards drafting legislation—we spent a fair bit of time. The next list, I guess, are issues that

are not necessarily recommendations because as an association we remain opposed to euthanasia and physician-assisted suicide. But there are a lot of suggestions that we can make and views that we have formed quite strongly. I should say that what I am sharing with you now has been through the AMA WA's council; it is not just the outcomes of the actual symposium, but it has been filtered through the council because that is the policy-generating body at AMA WA. They are that we should go carefully and slowly, considering all of the unintended consequences, the impact on society, on other legislation, on practitioners, to consider the details such as the methods, the actual drugs—are they TGA listed—because the types of drugs that some places are using are not available in Australia. How would you get them; how would you regulate them? If you were talking about a self-administered model and you prescribed a set of highly toxic medications to somebody who chose eventually not to use them, how do you get them back and avoid these medications being available in the community and being abused? We would want to make sure that the training and the way that any medical professionals involved is organised and very structured, make sure that the supports and everything are in place for any medical professionals—be they doctors, nurses or whoever who are involved—and make sure that the impact on them of actually ending people's lives are considered and they receive the support they need.

The one strong message from our association is that if we go in this direction, any doctors that are involved should opt in to be involved and they should receive mandatory training—that is, training in the laws, obviously, to make sure that they are crystal clear on their responsibilities—that they have specific training in having the discussions, because these are really, really important discussions, and that they receive training in the methods that are going to be utilised to end somebody's life, and that they are also formally connected to a support system to make sure that they are not harmed as individuals. I will get on a little bit later as to whether doctors need to be involved because I know that is one of your questions. In terms of indications, the view of the AMA WA is that if we go down this path, we would strongly recommend a very restricted model making voluntary assisted dying available to people with terminal illnesses only. These definitions are really, really important and a good period of consultation about any proposed definitions should occur prior to drafting legislation. We strongly believe that broad access to anybody who perceives they are suffering is far too dangerous to the fabric of our society and to individuals—dangerous because it will fundamentally change the practice of medicine and how we perceive our fellow man in society. We recognise that a restricted model will not satisfy everybody, but if you are going to go down this path, we would strongly recommend a safe approach rather than a dangerous approach.

The preference of AMA WA is for self-administration to be the model, such as in Victoria and Oregon, rather than a physician or healthcare professional-administered model. That respects the concept of autonomy. If the reason for offering the service is to respect people's autonomy, then it follows that they should take the ultimate gesture themselves. Obviously, some people in this situation who are competent lack the ability to deliver it themselves and some form of assistance from either a family member or some other individual is reasonable in those circumstances as long as it is tightly controlled.

Competence is a really important discussion. We heard evidence that this is very difficult to define in the context of people who are dying, but we would put it to you that a very high bar of competence should be guaranteed because there is no higher stakes decision than whether to end your life or not. It is a higher stakes decision than granting power of attorney to a family member in the event that you become incapacitated. We heard, and I think you have heard as well, from palliative care physicians who talk about the waxing and waning of competence and of mental state during terminal illness. Of course, we know that depression is a very common comorbid state with

people with cancer and other terminal conditions, as high as 40 per cent. Of course, there are other conditions that may affect competence such as anxiety disorder, psychosis and, of course, the medications that are being used to control symptoms. Speaking on the radio yesterday, we heard a story of somebody who ended their life in the Netherlands. In order to make sure that they were competent for their final act, they had to withdraw all opiate treatment for 24 hours, so a patient who is tolerant to and addicted to opiates, which is inevitable when you take these sorts of doses, has that withdrawn so that they are competent but that means they have a day of much increased pain and opiate withdrawal prior to ending their life. That would seem to be a regrettable situation. I think a better model can be found. We believe that competence needs to still be in place at the time of the termination of life and some kind of predetermined view would be inadequate to guarantee that the decision is still the view of the patient, because we know—I have heard lots of evidence and I am sure that you have as well in this committee—that the views of individuals change over time as they go through their illness, and even people who go so far as to get approved access to euthanasia do not always follow through on the act. Sometimes that is because nature takes its course, but sometimes because they simply change their mind.

We heard from Professor Finlay from the UK about the safeguards put in place in the various jurisdictions and her scepticism as to the effectiveness of those safeguards. Really the point is that everything is far more complex in reality than it sounds when you are writing down rules on a piece of paper. A key example, one that has stuck in my mind, was her example of the most wrong she has got prognosis as a palliative care physician where an individual she talked about was given a few weeks or months to live and is still going strong decades later. We do get prognoses wrong and we need to understand that everything we talk about is grey when we are talking about end-of-life issues.

In terms of the decision to proceed and an approval process, we are not comfortable with two independent doctors agreeing with each other. We find that to be fundamentally flawed. If an individual wanting to seek euthanasia did not meet the criteria by two particular doctors, they will go and find another two doctors that do agree with them. We know this occurs right now in medicine in Western Australia where if doctors do not give you the answer that you want, you just go find another one. Doctors are good at certain things in medicine, we are okay at other things, but we are not skilled in all of these sorts of decisions. We are not skilled in legal decisions, we are not skilled in knowing what underlying motivations there might be behind a decision to proceed with euthanasia, we are not skilled at knowing whether coercion is occurring, we are not skilled at knowing the impact of a will on a family when we are talking about these complex decisions at end of life. The view of AMA WA is that a panel or tribunal-type model for final approval would be our strongly preferred model. We did hear that this could be overly bureaucratic and legalistic and not the right sort of environment for people at end of life, but we also believe, as I said before, that this is such a high stakes decision, it would be unconscionable to get it wrong or to put in a structure that was ripe for abuse or that just did not achieve the outcomes that they were all hoping for.

[10.30 am]

There would obviously need to be medical input into that kind of panel or tribunal decision, but we feel that it would be strengthened by the presence of legal expertise and independent individuals as well. We have these sorts of models in practice right now with regard to the administration tribunals and models like that, and we believe that an appropriate model could be designed.

When making that decision, there were two factors that the symposium felt were very important. One was ensuring that an appropriate medical treatment had already been offered and delivered to the patient, including palliative. There should be a mandatory palliative care assessment to make

sure that a patient is not choosing to end their life because they have not had appropriate medical care or not had access to appropriate palliative care. We heard evidence from Dr Gubitz from Canada that some of the patients that he went to see in order to provide them with euthanasia, he found them ineligible because they had not received that level of care; in fact, they had not had palliative care whatsoever. Certainly, we believe that euthanasia, or physician-assisted suicide, should not be available to people who have not had access to appropriate palliative care.

Similarly, the discussion around diagnosis of depression and other mental illnesses that are comorbid with terminal illnesses is very difficult for the average doctor and very difficult for a palliative care physician or any non-psychiatrist, and, in fact, is probably difficult for psychiatrists as well. Our strong recommendation is that a psychiatric assessment be completed for everybody accessing this option, partly around competence, but we do recognise that other doctors can assess capacity and make recommendations about legal competence, but mainly to exclude significant mental illness. We know those rates of mental illness are extremely high in this population and we would not countenance access to euthanasia because someone is depressed. We feel that would be an inhumane treatment. I have already mentioned the fact that the patient needs to remain competent throughout the decision-making process and at the final act due to the acknowledgement that people do change their minds through the process.

The next question we have posed was whether euthanasia or physician-assisted suicide is a medical act: is this medicine at all? The answer to that is probably no. Certainly, there is a lot of sympathy within parts of the medical profession for the idea that this should be someone else doing this; it should be a non-doctor, a patient, a family or some other practitioner who delivers this, because this is not medicine. Medicine is about helping people, relieving suffering and preserving life, and this is the opposite. This is not a unanimous view because we recognise the practicalities that doctors possess the skillset required to deliver certain types of euthanasia, and that skillset is not currently held by any other group, but we do believe that this is a debate that should be had: is this medical care or not? If you are going to go for a third party-administered model, who should actually administer the care? Obviously doctors want to be involved in the discussions. We want to be involved, as we are here today, in the design of legislation. We want to be involved in the decision-making, because these are very medical decisions. But the act of ending a life is not medicine. A number of our members have a lot of discomfort with the concept of delivering the care. Some would do it. Given the fact that certainly in Oregon and so far Canada we are looking at less than one per cent of all deaths, if you did implement a restrictive model, you would not need a whole lot of doctors; you would need a small number of highly-trained individuals to deliver the care if it was doctors doing it. The reality is that there probably are those people available in the community, but it does not necessarily have to be a doctor.

I wanted to raise the impact on Indigenous communities. I am not sure whether you have had the opportunity to discuss these issues with Indigenous representatives. We invited an Indigenous representative to our symposium. We were not able to fully explore the issue, but we are still concerned that if the medical profession generally is associated with ending people's lives, that may create a further barrier to our Indigenous population accessing medical care. We know that some of their views around death are quite different to those of the western mindset. That is already a barrier to seeking medical care for certain Indigenous members of the community.

To summarise all of that, I think it is fair to say that the Australian Medical Association of WA is significantly opposed to a liberal model of euthanasia that made it available to people with anything other than a terminal illness. We believe there would be inevitable damage to society, the aged, the sick, the mentally ill, potentially the Indigenous people, not to mention the normalisation of suicide. Of course, suicide is already a huge health issue for us and we put significant resources into

preventing it. We do not believe this is a completely safe model anywhere in the world for the provision of any form of euthanasia, but in the event that that is the decision of the Parliament, we are calling for the safest possible model with protections for the vulnerable and protections for individuals practitioners; for decisions to be made by appropriately constituted tribunals or panels; for all health professionals involved to be appropriately trained; for eligibility criteria to be strict; for assessments to be very robust; and to make sure that in the event it is implemented, that we follow what happens very, very closely, that we collect data appropriately and that we fund this. This is an expensive exercise. To make it available and to make it safe and appropriate and delivered properly it will cost a lot of money and that needs to be funded. We need to make sure that everything, all the little details that need to be put in place, are put in place before the community is given an expectation that it is available to them, not as an afterthought, otherwise we will follow the same mistakes that have been made in other jurisdictions. In particular, we would like to strongly stress the need to word legislation so tightly that slippery slopes are avoided and that definitions are not open to interpretation by individual medical practitioners or individual patients, so that it is really clear what is available and what is not.

The most critical point, it will be no surprise to you hear this from me and from the medical profession, is that 99 per cent of the community's deaths will not be through euthanasia. Our strong, strong message is that we need to improve palliative care and end-of-life care for the other 99 per cent. If we do that, we believe that community support for euthanasia will be dramatically reduced. A lot of that community support is because our end-of-life care is not delivered in an optimal way at the moment. If we get that right, it will save us money in the big hospitals; it will improve patient outcomes and satisfaction; and, most importantly, limit the suffering of those at end of life.

To close, I guess from the symposium, probably the most poignant individual comment from the whole symposium was that of Theo Boer. When Dr Noonan asked him what was his advice to AMA WA in this debate, he said that if he looked in the bottom of his heart, he would say, "Don't go there." This is the position of somebody who has been a supporter and who is an ethicist and has thought a lot about it and had a lot of experience, but he has seen, I guess, a liberal model and the damage that has done to his society. That is not necessarily a widely held view in the Netherlands. I know there would be a lot of very strong supporters of what happens in the Netherlands. But someone who has thought about it deeply and been deeply involved has said to us, be very, very careful, and I think we should heed that message. We recorded the speeches given by the international guests and we have the recordings of the skype interviews that Dr Noonan did with the Canadian and Dutch experts, so if those are of interest to you, we would be happy to make them available.

The CHAIR: Yes, please, that would be very useful.

Thank you very much, Dr Khorshid; that was a very good effort. You have covered a lot of what we were going to ask. I have a few questions and I might hand it to my colleagues. The symposium was for medical professionals only. Did you canvass the views of patients or the community as part of the symposium?

Dr KHORSHID: The idea of the symposium was to provide a forum for our members to talk to us. We think it would be a valuable exercise for someone to run a more open symposium hearing those sorts of views and including hearing patients' views. But what we did not want was a huge media circus. We wanted us to be able get our house in order and to cement our own thoughts. If we ran an open forum, we expected that it would be just a media circus. As we have seen with the recent death in Switzerland of our elderly Western Australian, it is easy for messages to get mixed up in

the media. Sometimes there are unintended consequences of those things. In the spirit of, if we are going down this path, I think it would be a valuable thing. One thing we have noted is that the closer doctors get to end of life, the more opposed they are to euthanasia. The more experience they have with dying, the more opposed they are. We have heard those views from a few individuals in the community just on the radio yesterday and some other people we have spoken to when they have experienced good palliative care have actually changed their view on euthanasia. A lot of the drive for euthanasia is the fear of an unpleasant death or the fear of lack of palliative care, and they want to have control over their death. But what people do not necessarily realise is that for the majority of us, this legislation will make no difference to your end-of-life treatment because you will not meet the criteria, or you might not want to, or it will be inappropriate for a whole series of reasons, including dementia and so on. This is such a broad debate. We would certainly encourage the community to be engaged as much as possible in the broad debate, not just the question of access to euthanasia and physician-assisted suicide.

The CHAIR: But the evidence you put to us today is not the view of the patients.

Dr KHORSHID: The evidence is the view of the medical profession.

The CHAIR: Who was the Indigenous representative?

Dr KHORSHID: We had Deborah Cain, who is a cultural safety officer at the Aboriginal Health Council of WA. She is somebody that we had a conduct with and she was happy to come and give us an Indigenous perspective on things. She is not a Western Australian originally, but she does work very closely with our Western Australian Indigenous population.

The CHAIR: I might come back to that. In terms of the evidence given by one of your speakers around suicide increase, did he provide empirical data to support that?

Dr KHORSHID: That was a verbal comment made in an interview. Dr Noonan might be able to answer the question whether he has given her any specific data.

Dr NOONAN: Or a research paper. He did not cite the actual paper to me, but I would be happy to follow up with him and get that source.

The CHAIR: Yes please. It is slightly in conflict with some other data that we have seen so it would be interesting to see any empirical data to actually back it up.

Mr J.E. McGRATH: Further to that question, I was interested in what you said about the increase in suicides in the Netherlands. Did that person indicate how those people carried out the suicide? Was it similar to how people ended their life taking Nembutal or some substance?

Dr KHORSHID: He did not make any comment on the method of suicide. He was just speaking on the idea that suicide as an option for the relief of suffering had been normalised in the Dutch society and that he felt that was a negative step. That was the point he was making. He did not comment on whether people were using the same drugs or similar mechanisms. I do not know whether that data is available in the Netherlands.

Mr J.E. McGRATH: You would think if there was a system that was available to people, why would you commit suicide if you could do it through a system that was sanctioned by the government?

Dr KHORSHID: I do not think the Dutch would characterise their system as a suicide free-for-all. They still have some criteria. A lot of suicide is for mental illness or depression. It is not because people have intolerable suffering with chronic diseases. But the point he was making is that suicide is seen more and more in Dutch society as a reasonable way out of whatever your existential suffering is. He gave a specific example of a suicide of a woman—he did not mention how it happened—in a particular area in the Netherlands in a big town.

The paper in that town had a six-page spread on this young woman, from his point of view, almost celebrating the fact that she had taken this courageous decision to end her life through whatever suffering it was. I do not think he gave us the exact reason that she ended her life. That is just an example of how rather than regarding suicide as a tragedy, which is our normal response, it was being seen as a reasonable option to get you out of the situation that you are in.

[10.45 am]

The CHAIR: Any empirical evidence around this is useful. There is a lot of anecdotal evidence in this debate and there is a lot of data. It is our job to look at the evidence. If your speaker is able to provide that, it will be really helpful.

I want to go back to your interesting point that if we are focusing on a voluntary assisted dying model, it is not medicine. I think the community would probably agree—those who support it. It is not necessarily medicine. We have had a lot of evidence from people who have had experience of end of life and have said that, by and large, doctors are not present when people die, if they die in a hospice setting or a community setting. The community should therefore be cautious of putting too much weight on the views of the medical profession around this. I am interested to see if you have a view, given your members' view that it is not medicine. Do you have a view on that?

Dr KHORSHID: I think I would challenge that statement. Being present at the actual time that the heart stops beating or the breathing ceases is probably not that relevant. It is really sharing the journey with the patient—exploring their feelings, their symptoms, and relieving the suffering. Doctors absolutely do share those journeys with patients all the time in general practice, in palliative care, in many branches of specialist medicine. We deal with death as a concept more than any other area in the community. Obviously, we may not be present at the time, but I do not think this debate is about what happens in the last 10 minutes or hour or two hours of life. This debate is about how we relieve suffering. We are talking suffering over months and years, not suffering over a very short period at the absolute end of life. I would strongly recommend, obviously from a somewhat biased position, that the views of doctors are very important. But they are not one. There is a range of views in the medical profession. I think I have tried to share that with you. But the unanimous view of the medical profession is that the focus should be on palliative care. Even those doctors—around half of our symposium were supportive of euthanasia; half the people who attended. They were unanimously of the view that the focus should be on palliative care. That is what we need to invest in as a society. Even if they believe that euthanasia should be available too, they still think the focus has to be on palliative care.

Hon ROBIN CHAPPLE: Thank you very much indeed. In relation to this, Dr Khorshid, you had your symposium on 5 May and it was attended by all doctors—when I say all doctors I do not mean every doctor in the state. I mean all types of doctors. It was not just your AMA membership—it was broader medical professions?

Dr KHORSHID: No, it was a members-only forum. We have between 5 000 and 5 500 members, and a good proportion of the actively practising doctors in Western Australia as members. We had 250 registrants, of which just under 200 attended. As I said, they had a breadth of views, as does the medical profession generally. They were spread from medical students, junior doctors, registrars who are training, specialists, a lot of general practitioners, a lot of psychiatrists, a lot of palliative care physicians and a whole pile of other doctors. There was even another orthopaedic surgeon there. I was not the only one. There were anaesthetists. There was a really good range of doctors—of different ages as well. One thing we kind of expected was that we might see a lot of older members. Our membership is a little bimodal. We have lots of young members and lots of old

members and not as many in the middle. We kind of thought that maybe it was the older members who would attend this sort of symposium, but actually it was broadly representative.

Hon ROBIN CHAPPLE: Following on from that, did you have many GPs attend? You had GPs attend?

Dr KHORSHID: Yes.

Hon ROBIN CHAPPLE: Your membership in WA I think is about 50 per cent of medical professionals, whereas nationally it is about 30 per cent. Is that correct?

Dr KHORSHID: Yes.

Hon ROBIN CHAPPLE: At the symposium you held, was it only WA members who attended?

Dr KHORSHID: Yes.

Hon ROBIN CHAPPLE: I note you have a speakers list on your table. Could you table that for us?

Dr KHORSHID: Yes, I would be happy to table that—absolutely.

Hon Dr SALLY TALBOT: I cannot remember your exact words, but at some point in your presentation you talked about the symposium and presumably what has been ratified by your board was a proposal that if we were to introduce voluntary assisted dying laws, that there would be special training, advice and support services provided to the medical profession. You have obviously been following our proceedings closely. You will know that we have had volumes of evidence about the fact that doctors and other medical people are currently participating in practices that, effectively, end lives. That, of course, is completely unregulated at the moment and unreported. We have also heard a lot of evidence from the medical profession itself about the fact that the laws as they exist now are, to put it mildly, opaque. They certainly do not provide clear guidance on the ground for doctors in terms of their practice. My question to you is: what services do you provide currently in terms of advice and counselling and support for doctors when it comes to end of life?

Dr KHORSHID: There are a couple of points. I think the AMA would not agree with the statement you made that there is some kind of unreported wave of euthanasia or doctors ending people's lives illegally in Western Australia. There may be isolated cases, some of which have been well publicised.

The CHAIR: Can I just clarify? I am not sure the member said that the practices were illegal.

Hon Dr SALLY TALBOT: No.

Dr KHORSHID: Okay; good.

Obviously, doctors are involved in end of life. We see a big difference between relieving suffering, which may bring forward death a little bit, although there is evidence that it probably does not, but it could, and you cannot say it did not because you are not really sure. You do not know when death was going to occur. That is very uncertain. We see a big difference between that and undertaking an act deliberately which ends somebody's life. You may not see that, but we do see that. We believe that if individuals start to provide this service and it becomes a significant part of their practice, that they will require specific training and support. They may be robust individuals and they may not agree with that—those who choose to participate. Our belief is that this is not part of normal medicine and that if we are going to introduce it, we should look after those people who are providing that service. The AMA is a membership organisation that provides services to members. We do not have a function at the moment to provide support for members—not specific support—who are having difficulty with the things they have to do in their workplace, but we provide general support, as most membership organisations do. We provide advice in specific instances and that sort of thing. I do believe that we, as a community and as a medical profession, do need to do more

to promote end-of-life discussions generally, as I have already said. Some of that would include support for individuals who are having difficulty as practitioners.

Hon Dr SALLY TALBOT: Just so that we understand, there is no training and support provided currently?

Dr KHORSHID: Not for providing end-of-life care, because that is not provided. There may be—I am not aware of what is provided to and within palliative care communities. They may well have some structured support. I am not aware of that.

Hon Dr SALLY TALBOT: So it would not be the AMA providing this training and support?

Dr KHORSHID: No.

Hon Dr SALLY TALBOT: I realise that this is not a fully developed policy, but can you just give us an account of what that might look like?

Dr KHORSHID: Our general view is that if a group of medical or other practitioners became the group that delivers the service to the community, that that group be organised, trained and supported by government—by whoever is providing the service, whoever is paying for it. Obviously, the AMA would be willing to participate in that process and possibly even provide services. We do a lot of training and provide services to our members in a semi-commercial way as well. We could be part of that but the responsibility for that would rest with government, who is providing the service, as it does with all the services we provide in public hospitals and other government institutions.

Hon Dr SALLY TALBOT: Maybe we could just tease out exactly what you mean by “if there was a group of doctors who were willing to provide these services”. A couple of witnesses have made the suggestion that perhaps there should be a register of doctors who have ticked the particular box that they are willing to provide or at least enter into discussions about end of life. Is that what you are envisaging as an organisation?

Dr KHORSHID: We would want it to be as tightly controlled as possible. A register is one way, but we would probably suggest even more control so that there is a single service or certain services that are defined and are well known to the public, so that the public can access them directly rather than having to go through their doctor necessarily. Obviously, some doctors are conscientious objectors and would not want to refer or be compelled to refer. If you have services that are well known—there are examples overseas of services that are well known—euthanasia and physician-assisted suicide could be only available within those types of services, whether they be government or private probably does not matter.

Hon Dr SALLY TALBOT: Can you help us by making a comparison with other fields of service delivery by the medical profession that have been equally contentious? What immediately comes to mind is abortion, assisted fertility services, various procedures around pregnancy and termination of pregnancy. Is there a currently existing system where people opt in or are on a list of people who provide those services?

Dr KHORSHID: I do not believe there is for people who provide terminations of pregnancy, but they have organised themselves into public-facing bodies often. Obviously, in that area, like the euthanasia area, because a lot of our services are delivered by the Catholic hospital sector and other religious groups, there are barriers to access to contraceptive and termination of pregnancy services that would be mirrored in the euthanasia debate. You would need to set up a system where this is not just—in our view, anyway—something that is provided by general doctors, GPs or specialists in hospitals, because a lot of those hospitals will probably not want to participate and will be very reluctant to have anything to do with it. Rather than putting barriers like that in place and saying that if you go, for instance, into the Catholic hospital sector, you cannot access this service because

they just do not agree with it—which is what is currently the case for termination of pregnancy and contraceptive treatments—we would suggest that if an individual wants to access the service, they will know where it is because it is obvious; it is on the internet, it has a name. It might be government or private sector or there might be multiples of them, but they are accessible directly to the patient; then you know what is going on.

Hon Dr SALLY TALBOT: Broadly speaking—I am not trying to put words into your mouth; I am genuinely trying to understand your position—you would say that the same criteria would apply to euthanasia or voluntary assisted dying as currently apply to terminations of pregnancy?

Dr KHORSHID: No, I would not like to say that because I have not explored that in enough detail. What I would like to say, and what the AMA position is, is that you need very tight regulation, control and reporting. We want to know that it is being done appropriately and consistent with the law, that it is accessible to the appropriate patients who have the need and not inaccessible due to those other factors, and that you can oversee it; there is oversight and we know what is going on. This is a service that has significant dangers to society. As a system, I want to know that —

[11.00 am]

Hon Dr SALLY TALBOT: I do appreciate that point. And I do assure you that I am not actually having a go at you, I am on your side with this one; I am just trying to seek clarity. It sounds to me a little bit different to what I heard you saying in your earlier response to my question, which sounded to me more like a clinic or a shopfront somewhere that would be the provider of these services, so that a person would not necessarily go to their GP; they would go this shopfront to access voluntary assisted dying services. That is not the case with the termination of pregnancies.

Dr KHORSHID: It is one model for the provision of euthanasia that exists in the world and it seems to be, at least at some level, successful and that people know it exists and they know where to go when they want to access it. We do not want to be in a situation where you have a commercial entity promoting suicide, we think that would be a real problem, but if there was a shopfront-type service, that is one model that could be considered. We do not support that or advocate against it. That is one model, but I guess the criteria that we have put in place in our discussions so far is that there is adequate training, that there is adequate regulation and that those individuals who provide the services receive the support, because we do believe that this is different to normal medical care. There is, of course, that discussion of whether it is medical or not, because if you have a system that promotes self-administration and you have appropriate agents, then you can take it away from the medical professional to some extent, but the reality is that the easiest way to ensure all of those things is to limit the number of services that provide it.

Mr J.E. McGRATH: You mentioned that at the symposium, I think, it was about 50–50 the feelings of doctors towards whether we should progress this looking at euthanasia, but then you said it went to the AMA council and they made the decision to endorse the policy or the position that you brought to us. Was that a unanimous decision of the council?

Dr KHORSHID: To be clear, the AMA WA council has endorsed the federal AMA position in the past. I think it was unanimous, I cannot recall exactly, but it was certainly a resolution of the AMA WA that we support the federal AMA position. The symposium was never about a discussion for or against euthanasia; that was not on the table. It was not discussed; there was no resolution to support the AMA federal position paper or not. It has been taken as assumed because we have previously made that decision. The symposium was about exploring the issue so that we could come back to you today and so that we can continue our advocacy knowing what our members think, and having that inform the council. But the symposium had no decision-making capability; it was not representative of our profession and we have our normal decision-making structures that do that.

It was never a possibility that the symposium would alter our advocacy in terms of whether we support the concept of doctors ending patients' lives deliberately. That was not discussed and not on the table.

Mr J.E. McGRATH: For an MP, like a lot of MPs, who does not know much about medicine, we are told that the government should act here because there is a risk that doctors could end up facing a criminal charge over a death, when, really, they did not do anything wrong but they still could face that charge. Do doctors and specialists go to work every day in fear of this happening or do they just carry on with the job? Is it a great fear within the medical profession?

Dr KHORSHID: I can say very emphatically that no, that is not a fear. That has not been communicated to us by any of our members. That is proven by the lack of prosecutions over the decades. There have been a couple of cases. We actually had a legal expert from MDA National at our symposium to show us a couple of those cases that happened over the years, including a couple here in Western Australia, but doctors just have not been prosecuted. It is not fair to say that there is some terrible risk that they are going to be, and we do not fear that. The symposium did not recommend any changing of the laws of things like the doctrine of double effect because we just do not perceive it to be a problem. The issues around end-of-life care are all at the resourcing and implementation and training phases; we do not believe that there is a legislative gap at this stage.

Hon NICK GOIRAN: I will just take up on that last point, then. You say there is emphatically not a fear, so the AMA position is that the current protections for practitioners in the Criminal Code are sufficient?

Dr KHORSHID: That is correct.

Hon NICK GOIRAN: One of our terms of reference—in fact, it is our first term of reference—asks us to identify the current end-of-life choices available to Western Australians. Would you include palliative care treatment as a current end-of-life choice?

Dr KHORSHID: I think palliative care treatment is an end-of-life right. We provide our community with medical care—that is our job as a health sector and, obviously, as a government—and palliative care is a key medical treatment because the one thing that is absolutely certain for all of us is that we are going to die and some of those deaths, without medical input, are very, very unpleasant. I am not sure that I would call it a choice, but we believe that absolutely every patient who has a need for palliative care has the right to receive adequate palliative care. The number of people for whom palliative care is inadequate is very, very small. We acknowledge that there are some, but it is very small.

Hon NICK GOIRAN: If it is an end-of-life right—we do not impose palliative care treatment on people; they choose whether they want to accept that—would you say that palliative care treatment is then not only a right but also a current end-of-life choice available to Western Australians?

Dr KHORSHID: Every medical intervention that a patient receives is a choice; they do not have to receive it, we would never impose treatment on patients, and that is very clear in the law. I think we would take a broad view of the definition of palliative care: it is not just about the last week of life and putting people on morphine infusions; it is actually about relieving symptoms. I do some palliative care in my specialty of orthopaedic surgery. When patients fall over and break their hips, they are often at the very end of life, but the best thing we can do to relieve their symptoms is actually to perform a potentially risky operation which gets them back up on their feet and relieves their pain for the remaining time that they have—sometimes that is very short. Palliative care is a pretty broad concept and it is about relieving symptoms rather than trying to achieve a cure. I think

it would be a very unusual thing for patients to decline medical treatments aimed at relieving some symptoms, but they have the right to decline a particular palliative care intervention absolutely, and that is a choice that they have.

Hon NICK GOIRAN: I am appreciating that what you are saying is that palliative care is available to people not just at end of life and those final few weeks, I accept that. The job of this committee, though, is to report back to Parliament and list what are the current end-of-life choices available to Western Australians. I seek your clarification as to whether palliative care treatment is one of those choices available to patients at end of life?

Dr KHORSHID: I would say, yes, it is, if you frame it in that way, along with many other choices such as where to die, such as what other medical interventions might be occurring in order to preserve life. Some patients and families have very unrealistic expectations of the chances of surviving an illness and rather than doctors always fighting to preserve life, which we heard about a lot in this debate, there is also the situation where doctors are saying to families, “This is futile. It is not going anywhere”, and that can be a very, very difficult discussion. Sometimes, unfortunately, doctors have to remove the choice from patients or families because the care is futile and it is not reasonable for society to keep paying for it and it is just causing more and more harm. So, yes, the choices are varied and I am not sure how it is going to be defined in your report, but, yes, palliative care is a choice, as is every other type of medical treatment.

Hon NICK GOIRAN: Okay, so we have medical treatment. One of those medical treatments is palliative care. Also, the refusal of medical treatment is an end-of-life choice for Western Australians.

Dr KHORSHID: Yes.

Hon NICK GOIRAN: Would you also include terminal sedation, which is sometimes referred to as palliative sedation therapy? I think that is the other phrase that is used. Would you include that as a current end-of-life choice for Western Australians?

Dr KHORSHID: I would include that as a subset. It is a technique utilised, as we understand, by palliative care physicians usually, or those doctors delivering palliative care. It is not a choice available to patients who do not need it, because then it would not be terminal sedation or palliative sedation anymore; it would be, actually, euthanasia. I would rather just characterise it as one of the number of techniques used to relieve suffering at the very end of life in the delivery of palliative care.

Hon NICK GOIRAN: What about the refusal of food or water?

Dr KHORSHID: That has been clearly demonstrated in law to be a right that patients have by case law, in the Rossiter case. And yes, that is an end-of-life choice.

Hon NICK GOIRAN: Advance healthcare directives and advance care plans, would you describe them as current end-of-life choices for Western Australians?

Dr KHORSHID: This is a personal view, but probably not. Again, they are discussions, they are topics, they are very important and they are tools. In the case of the advance health directive, it is a tool that is available to make sure that patients’ wishes are heard in the event that they no longer have capacity. You have a choice as to whether or not to enact an advance health directive. You have a choice to participate in advance care planning, and some patients choose not to; they find the discussions very challenging and they choose not to. In that sense, it is a choice, but would I characterise it in your list of choices? Probably not.

Hon NICK GOIRAN: More of an instrument to record the choice than a choice in itself?

Dr KHORSHID: That is correct.

Hon NICK GOIRAN: What about suicide, is that something that you would describe as a current end-of-life choice available to Western Australians?

Dr KHORSHID: I would. Suicide is legal, as I understand it, in Western Australia, and it is a choice available to anyone in the community at any time, yes. We do know that people suffering with chronic disease and a lot of elderly people do commit suicide. That is a known fact.

Hon NICK GOIRAN: You mentioned that there is no group other than doctors who have the skills to perform euthanasia. I think I heard you say that earlier.

Dr KHORSHID: Yes.

Hon NICK GOIRAN: I just seek your clarification on that, because I understand that vets do perform euthanasia in a somewhat common fashion.

Dr KHORSHID: There are some overlaps between medicine and veterinary science and, obviously, euthanasia is administered frequently by veterinarians and never by doctors. The difference is that we are dealing with people, not with animals, and we need to understand issues like competence, capacity, depression et cetera which vets just do not have to consider. I would be very cautious of, and we hear it commonly in the community, this idea that we have more compassion for our animals because we look after them at end of life and we do not look after our families. I think that is a pretty weak argument and very dangerous territory. But in terms of the mechanism of achieving death, yes, veterinarians are skilled at that; they administer usually an intravenous barbiturate, from what I understand, and that is commonplace, whereas doctors do not currently deliberately end people's lives. But I think international evidence has shown that doctors have the skill set to do that, where they are asked to do so and where they agree.

Hon NICK GOIRAN: But you did say earlier that doctors are not skilled at identifying coercion?

Dr KHORSHID: Yes.

Hon NICK GOIRAN: I assume then that since doctors are dealing with humans and vets are dealing with animals, there would be no basis to assume that vets would have the skills to identify coercion if doctors do not.

Dr KHORSHID: Absolutely, they will be much less likely to be able to deal with the complexities of dealing with people than doctors are, because, obviously, no matter what type of doctor you are, you have a lot of experience in talking to individuals at difficult times in life and exploring issues.

The point I was making about coercion was more that a doctor assisting a patient at the end of life will not have the information they need to know the full context in which a decision is being made. In our view, it is preferable for a system to be put in place where that information is available to those who are making the final approval decision so that we can protect the community.

[11.15 am]

Hon NICK GOIRAN: Yes, you have said a couple of times today that your preference—of course, you are speaking on behalf of the AMA—is such and such, but, of course, as I understand it, the AMA's preference is that there be no change to the law. I think I have recorded your comments as being that the position of the AMA remains the same—that you are opposed to euthanasia or physician-assisted suicide.

Dr KHORSHID: That is correct. These comments are prefaced by “in the event”, because we do feel that —

Hon NICK GOIRAN: In the event that we ignore Professor Theo Boer, and we do go there—that is the context of the comments?

Dr KHORSHID: That is the context of those comments, yes.

Hon NICK GOIRAN: Sure. You mentioned that the AMA does not believe that there is a completely safe model and I think I heard you say that there was a Dr Finlay from the UK who provided some critique on the effectiveness of safeguards. Were any of the other experts at the symposium able to comment on the effectiveness of safeguards?

Dr KHORSHID: Let me think about that for a moment. Dr Gubitz is a provider in Canada and he shared his personal experiences. He is not particularly involved in the structure or the review, like Professor Boer from the Netherlands, but in sharing his personal experiences, he was able to make it clear to us that the processes were not terribly robust in Canada. The evidence we heard was that they would generally agree with that and they have work to do before they have a system that they would promote to other countries as being good.

Hon NICK GOIRAN: Because they were rushed.

Dr KHORSHID: They were rushed; that is right.

I do not think any of the other speakers specifically spoke at length on safeguards.

Hon NICK GOIRAN: So the main expert who presented on safeguards was Finlay. Was any jurisdiction identified where safeguards had not been breached?

Dr KHORSHID: Her view—I am paraphrasing it here—as I understand it, is that nowhere are the safeguards perfect because the innate nature of these discussions means that there is always uncertainty. There is uncertainty about prognosis, there is uncertainty about competence, there is uncertainty about family dynamics and, as I mentioned before, coercion et cetera. Any system that you put in has limitations on how effective it can be at ensuring that rules are being followed et cetera. She gave some specific examples; I do not have them in my mind, but even in places like Oregon, where there is a pretty restricted model, she still had issues with their safeguards. Her think tank, Living and Dying Well, is predicated on injecting evidence into these debates around the world. I am not sure if you have accessed their material at all, but they are a group who has this discussion and can provide a lot of evidence, so they may be a good source for details around that. We have also had access to some material from Professor Finlay; she has written an article for us in our latest magazine, and there was a recent journal article that she shared with us that has been published by her and some other thinkers from the US on the topic of decision-making around euthanasia and doctors' involvement and safeguards and that sort of stuff, so we would be happy to share that. That is a published journal article that has been peer reviewed. We would be happy to share that as well.

Hon NICK GOIRAN: I think you mentioned earlier that you might make these videos available to the committee. Are they publicly available at the moment?

Dr KHORSHID: Not yet. We have some videos that we did online to interview people that could not come. The whole symposium was videoed and we have not made a final decision about how publicly to share those, but we do intend to get them out there once we have edited them and got them in a publicly presentable format. Either all or some of them will be available to our members in particular, and probably to the general public.

Hon ROBIN CHAPPLE: But they will be available to us as a committee?

Dr KHORSHID: We are very happy to make them available to you separately.

Hon NICK GOIRAN: Just on that, would there be any objection to the committee, when we receive the videos, making them public?

Dr KHORSHID: We would have to get back to you on that.

Hon NICK GOIRAN: Could you take that on notice?

Dr KHORSHID: Yes, we will take that on notice.

Mr S.A. MILLMAN: Just on the international guests you had and the comments they made on safeguards, Baroness Finlay, you said, was able to comment on Oregon. Do you remember whether or not she was able to comment on whether she was aware of the Victorian legislation or able to comment on the safeguards in the Victorian legislation?

Dr KHORSHID: She does have an opinion on the Victorian legislation. Did you want to take that question?

Dr NOONAN: Not really.

Dr KHORSHID: I cannot recall in enough detail what she said, but she certainly has an issue with the nine-day cooling-off period, and I think other medical professionals that we have talked to are uncertain as to whether that is a long enough cooling-off period, so that is one aspect. The fact that it is within the last six months of life or 12 months of a neurodegenerative condition, self-administered where possible, is a generally safer model. But I think her take-home point for us is that no model is completely safe and that all of the safeguards have been demonstrated to fail, and she provided some evidence for that. Even with the euthanasia itself, I think she said that in six cases in Oregon, people had not died after consuming the oral barbiturate that they use in Oregon. We did not hear much from Oregon, unfortunately. It is a jurisdiction where this has been in place for a long time and, as I understand it, has not created a slippery slope arrangement. That is probably the kind of model I think Victoria was looking at when they went down their track, and it is one that we would generally be more comfortable with than, obviously, Belgium or the Netherlands. But, certainly, Professor Finlay's input was that you cannot completely safeguard this decision.

Hon COLIN HOLT: Congratulations on the symposium—a great approach to it. I see that one of your suggested criteria was a mandatory psychological assessment of anyone who wants to go down the path of voluntary assisted dying. Is that to assess decision-making capacity?

Dr KHORSHID: There are two aspects to this. One is capacity, which is medical terminology to determine competence to take a legal decision, and psychiatrists are experienced at determining capacity, but there are other doctors who are also experienced at determining capacity, such as geriatricians, who do it a lot in the dementia sector and the aged-care sector. The requirement and suggestion for a psychiatric evaluation was mainly to look for the presence of depression because although other doctors can determine capacity reasonably well—not every doctor, but you could certainly identify doctors who would be able to do that—it is difficult to separate clinical depression from expected sadness and other things that are going on in people's lives, and symptoms of drugs and side effects of opiates and all those sorts of things. We have heard from our members that this is a difficult area and that the average doctor, which this sort of legislation normally talks about—just “a doctor”—we would not be able to be sure that those doctors have the skills necessary to be confident that a patient who is seeking this treatment was not depressed, in particular, but also anxiety, psychosis and other mental conditions. Both, I guess, is the short answer, but particularly focusing on depression.

Hon COLIN HOLT: Because the stakes are so high, I guess, you want it to be mandatory.

Dr KHORSHID: That is right. We believe there is not a higher stakes decision than the choice to end your life. Even if you are in what you would consider to be a terminal phase, it is still a big decision; you cannot go back from it once you have taken the act. As a society, we believe that we should be requiring that that decision is made appropriately, in good faith, with a high level of certainty. We are never going to be 100 per cent certain, we accept that, but we should be doing everything we can to make sure that the decision is correct and appropriate.

Hon COLIN HOLT: Did the symposium explore capacity in other end-of-life decision-making, including the things Hon Nick Goiran talked about? One that comes to mind is do-not-resuscitate orders. That is an end-of-life choice. Is there a degree of capacity assessment when people make that directive or refuse palliative care or refuse medication or refuse other sorts of care that will sustain their life? Was that sort of capacity considered in the symposium or in discussions?

Dr KHORSHID: It has been, not necessarily in the symposium, but there have been discussions along those areas. The examples you have given are all quite different. Do-not-resuscitate orders in hospitals are really tools used to encourage a discussion about the futility of resuscitation when a person, in almost all circumstances in hospital, has a cardiac arrest. It is extremely unlikely that anybody who has a cardiac arrest on a ward is going to survive and leave hospital, let alone go back into the community. The level of capacity required to agree with that is lower than the level of capacity required to end your life voluntarily, in our view.

The CHAIR: Let me give you another example. Someone is in the terminal phase of their illness and they have elected to stop eating and drinking, to withdraw any nutrition or hydration. That is a legal end-of-life choice now. Is there a capacity assessment for people who make that choice now?

Dr KHORSHID: I am not an expert on this area, but my understanding of the Rossiter case is that there was a capacity issue considered as part of that.

The CHAIR: Post the Rossiter case?

Dr KHORSHID: I cannot answer that question, but I would draw the distinction between—the decision to stop eating and drinking is a right that we support and that the court has supported. Individual autonomy needs to be respected. The request for somebody else to end your life is different, and we are very comfortable with a high bar for capacity and competence for that decision, higher than is the case in normal end-of-life discussions because those are the more, I guess, natural deaths. They are letting a disease process or a voluntary decision take its course. Suicide is legal; stopping drinking, stopping eating is legal. You can do that at any point in your life and you will die eventually. We do not do a capacity assessment before somebody commits suicide. As I said, we are comfortable with the requirement for a high degree of confidence with the capacity of the patient to make such an important decision.

Hon ROBIN CHAPPLE: Thank you very much indeed, doctor. You mentioned quite early on in your talk about palliative care principles. I really was struck by that because quite often we hear that palliative care is almost outside the medical profession, when, quite clearly, I think what you are saying is that all doctors and specialists should actually be involved in those palliative care principles. Do you want to expand on that a little bit more for the committee?

Dr KHORSHID: Yes. This was a strong theme from the discussions in the first part of the symposium and we believe that this is probably where action will deliver the most bang for your buck in terms of investing in end-of-life care. There are many, many pathways to end of life, and we know there is a lot of contact with the medical profession in the last days, weeks, months, year of life; unfortunately, there is a lot of hospitalisation. There are doctors closely involved with patients at end of life and we accept that, in many cases, palliative care principles are not adequately

incorporated into care plans. People—doctors, patients and families—are sometimes very much focused on cures and on the tiny chance that you might live an extra year with another bout of extremely expensive chemotherapy or something like that. In some circumstances, the relief of suffering, actually asking the patient, “What do you want? What do you expect? Why are you here? What are your goals?” is sometimes forgotten, or thought of too late, once you have already gone a long way down a treatment path—a treatment path that can be expensive, unpleasant and so on.

[11.30 am]

Patients do seem to have a fear that the medical profession will make their end of life unpleasant—that they will be put onto a ventilator, that they will be strapped to machines that make them do this and that, and that they will be fed through a tube. We have to accept the fact that those perceptions exist for a reason, because that is the experience of some people. We hope it is not a common experience, but it is an experience that people are very worried about. When I have end-of-life discussions with my patients, they are universally of the view that they do not want heroic attempts to keep them alive in the event that their quality of life is not going to be any good. I do elective joint replacements on elderly people. They are not worried about death; that does not concern them. What they are worried about is poor quality of life. We do believe there is a lot to be done by the medical profession to bring end-of-life discussions forward in our interactions with patients, but also for families and patients to come in with a clear view and to communicate that and to feel enabled to do that and to feel that they have the space to do that. It is not a doctor jumping in and straightaway treating a patient who does not want it and does not need it.

We have medical specialist training, training in hospitals and all sorts of mandatory training that we must complete in a hospital setting, most of which is not well supported by the medical profession because it does not seem to be part of our daily jobs, whereas dealing with patients at end of life is part of a lot of the everyday jobs of specialists in hospitals and junior doctors and so on. Hospitals need to get on board. We also need to look at structures. For instance, we have heard stories about patients in nursing homes. If a patient has a fall, they must go to the emergency department and have a CT scan of their head if they are on aspirin. That is some kind of a rule that somehow has gotten into our aged-care sector. It is just bizarre because for most of these patients, even if you found something on the CT scan of the head, you would not do anything. Once you do find something, all of a sudden doctors think, “Oh, we have to treat this.” It is just very sad that we are in a situation where in order to protect themselves—which is why most of these rules are put in—people are forgetting about the patient. We would strongly be supportive of the health sector, the aged-care sector and the primary-care sector doing a lot more to increase our skills in palliative care and not relying on saying, “Okay, now I’ve failed. I haven’t cured your disease. It’s now time for palliative care to step in.”

Hon ROBIN CHAPPLE: That is the point I am really trying to get to. You are actually saying that palliative care needs to be part of your process, not some separate entity.

Dr KHORSHID: That is right.

Hon ROBIN CHAPPLE: Thank you. I have a couple of other questions, if I may. You obviously have 5 000 or 5 500 members. You had 200 of your members go to your symposium and you were saying that the symposium was not to change policy, but to look at the issues around this. How was that conveyed to your membership? Was a letter or an email sent out saying, “This is what we’re going to discuss”?

Dr KHORSHID: Yes, there were a number of communications similar to this one, which we will table. We initially informed them that we were going to do something and as it solidified—we knew who was coming and we were able to get Baroness Finlay, for instance—we sent out multiple

communications to members advertising the symposium. I do not think we turned anyone away. All members who wished to attend were able to attend. We also streamed it on the web to those in rural areas who wanted to attend, and a few members took us up on that. We laid out the purpose right at the start of the symposium itself. The four main purposes that I read to you at the very start were put out in the emails to members. Did we specifically say to them, “We’re not going to be having a debate anti versus pro euthanasia”? I do not think we said that, but we did say that we are exploring the area—palliative care, end-of-life care—and what we should be advocating for as an AMA —

Hon ROBIN CHAPPLE: Given your current policy.

Dr KHORSHID: — if the laws change, given our current policy; that is right.

Hon ROBIN CHAPPLE: Did you have any applications from GPs who were not members of yours to attend your symposium?

Dr KHORSHID: We had a number of people who are interested in the area who are not members indicate some interest and we declined their participation because this was a members-only forum. As a membership organisation, you have to provide value to those people who pay you fees. This was an unusual thing for us to do, and I hope that we do more of it on contentious issues in the future. But it was a decision taken by the leadership, and largely by me, that this be open only to members.

Hon ROBIN CHAPPLE: Further to that, your membership is made up of a range of medical professionals, specialists and doctors. In terms of GPs, what is your membership of GPs?

Dr KHORSHID: I cannot give you an exact number because our GP members are split between different categories. We have a number who identify as GPs, but then we have a number of husband-and-wife teams who have a joint membership. Our proportion is a little lower than it is of specialists because the AMA Western Australia provides more services to the hospital sector—because we are also a registered industrial body—than we do to general practitioners. But we have a lot of general practitioners as members.

Mr S.A. MILLMAN: I want to come back to the question of capacity. I do not know that this is so much a medical question as a philosophical question. If, when I have capacity, I have particular desires about the way in which I would like to be treated medically and then, as time goes by, I start to lose my capacity, how do you measure the extent to which you are going to respect my autonomy and your duty to me to respect my autonomy, as opposed to other considerations that come into play? It seems to me that you have to be a doctor, a philosopher, a lawyer and a counsellor. How is that balanced?

Dr KHORSHID: There are a couple of points. As I understand it, if you have an advance health directive made when you had capacity and you lose capacity, that is binding on the doctors who treat you. Your wishes, as they were written down at that point in time, are binding on your family and on the doctors treating you. However, most people do not have advance health directives, so that assessment of what your wishes were when you had capacity are communicated to your treating team after the fact. It might be one or two years after you made those wishes known to your family, and that has to be taken into context: how reasonable is it, does it match with what other people would do and those sorts of questions. Judgement calls are made. As you pointed out, it is complex but it is made with families, in particular. Occasionally, they can be very difficult discussions, particularly when there are strongly opposing views within families. Doctors often have anecdotes about having to navigate those discussions. There are even some circumstances where doctors have gone to court, especially with minors, when the family wishes do not match with what

the doctor thinks is reasonable. In the case of someone who does not have capacity—such as a child—they have actually gone to court to try to force a certain treatment outcome or to get a court to make a determination, but those are very rare.

Mr S.A. MILLMAN: There are famous cases in the UK of that.

Dr KHORSHID: Yes, but in the majority of cases, the discussions with families are very reasonable and the outcomes would be acceptable to the person who has lost capacity.

Mr S.A. MILLMAN: Thank you for that answer. One of the things that you said earlier was that this is more complex in reality than writing down rules on a piece of paper. That would be something that would go into the mix as well. The problem that that presents, though, is that when we talk about safeguards—you will remember I spoke earlier about safeguards—I think the view of the AMA is that the definitions need to be really clear to avoid slippery slopes or space for interpretation. There is a relevant paradox here where, on the one hand, you have all this complexity but, on the other hand, you want the clarity. Can I hear your view on that? Just to further complicate it, can you comment on the fact that we do not record palliative sedation on death certificates? Doctors have a tendency to record the underlying morbidity rather than palliative sedation.

Dr KHORSHID: The first point is that these are really difficult discussions and that is why we are not supportive of euthanasia, because we are not convinced you can be completely safe. But we heard evidence at the symposium from Jocelyn Downie, for instance, who is a supporter of euthanasia, that the Canadian law refers to “reasonably foreseeable death”. That is just meaningless to a doctor. As I said before, all our deaths are very reasonably and, in fact, completely foreseeable. In Victoria, we talk about a six-month prognosis, but, as I mentioned, doctors prognosticating on time to death is famously incorrect in both directions. That does not mean that you should just write catch-all definitions into legislation that would sound nice, because the problem there is that you then lose control over what you really mean. We would be advocating for definitions to be as tight as possible and for there to be consultation with the people who might be making these decisions to see—that is what Jocelyn Downie said to us—exactly what that word means to the doctors, to the patients or to the lawyers who might be interpreting these laws before you write it in, because it may be quite different from the intention of those drafting the legislation. Can you remind me of your second question?

Mr S.A. MILLMAN: I was interested in palliative sedation. You have mentioned the word “intention”. The protection that doctors have under the Criminal Code is that palliative sedation is fine provided the intention is not to shorten life. I wanted to combine “intent” with palliative sedation.

Dr KHORSHID: Palliative sedation in Canada was mentioned again by Jocelyn Downie—she seemed to have some knowledge of our laws here in Australia—as a somewhat grey area, because it is potentially a step up from the usual doctrine of double effect. However, our view would be that it is about intent and the intent is to relieve suffering. The difference is that in relieving suffering, the act might induce unconsciousness, which is pretty close to death. But in the context in which it is delivered, it is a very reasonable medical decision. Should it be on a death certificate? The purpose of death certificates has to be considered. In my view, when you are looking at why we have death certificates, we want to know data—we want to know who has what prevalence et cetera and what has happened. Is it important to know whether a patient received palliative care in the normal way or terminal sedation in the last two days of their life? I would put to you that it is probably not important from a population point of view. If you are concerned about whether terminal sedation or palliative sedation is hiding euthanasia, then putting it on a death certificate is not going to be the solution to deal with that issue. It would have to be some other mechanism for looking at what is done in palliative care by palliative care physicians if there is a worry that something is going on

under the table. We are of the view that there is no particular problem with terminal sedation if it is used appropriately and that it is not particularly important for it to be on a death certificate. When we get to euthanasia, that is probably a little different, because the condition did not lead to the death. If you are talking about euthanasia, the condition has not led to the death, particularly if you are going to the Netherlands where it is not a terminal condition. We believe that some analysis of what you would put on a death certificate and how that interacts with other mechanisms in the law would be very important. That was certainly a strong message from Canada.

Mr S.A. MILLMAN: There might be a philosophical argument that the condition is part of a chain of causation that ultimately resulted in the death, though.

Dr KHORSHID: Yes. We often tell our junior doctors that they have done the wrong thing if someone dies and they write down cardiac arrest as a cause of death. Okay; every death is due to cardiac arrest at the end of day, is it not? It is not the important thing. The important thing is: was it pneumonia, myocardial infarction or a stroke that led to it? That is what we want to collect as a community. We do not necessarily need to know the exact occurrences in the last few seconds or minutes of life.

The CHAIR: Just following on from the member's question around terminal sedation, under your understanding, is consent always sought prior to terminal sedation?

Dr KHORSHID: I have to say that I do not have a detailed knowledge of terminal sedation, and its existence only became clear to me as we entered into this debate.

[11.45 am]

I would make the general comment that consent is always sought in an appropriate way for all medical interventions, and terminal sedation is a medical intervention. It would not be instituted against the wishes of family or the individual; I would be very surprised if that were the case. But is it documented on a consent form that you are agreeing like we do for a procedure? I suspect not. It is more that you have entered into a mode of care, being palliative care, where together with the doctor and your family and the nurses, or it might be Silver Chain or whoever it is that is delivering the palliative care, that is a continuum and consent is sought along the way. If a patient was very terminal, lacked capacity but was clearly suffering, then it would be impossible to seek the consent of the patient to administer terminal sedation and that would be a discussion between the doctor and the family conducted in the normal way that other medical decisions are made.

The CHAIR: So capacity is not necessarily a key requirement for terminal sedation either?

Dr KHORSHID: I would suggest that in practice it is not because it occurs so late in the illness that capacity would often be absent from a patient who is receiving terminal sedation.

Mr J.E. McGRATH: Doctor, you said earlier that the AMA is not in favour of a person being able to go and find two doctors to support their effort for end of life. You suggested maybe a panel, which was actually mentioned to me by a surgeon I had a discussion with the other day. He admitted that a lot of doctors really do not want to be involved in this. He said it could be done with a panel. How could you see a panel working and surely you would have to have a couple of doctors on the panel?

Dr KHORSHID: Yes, I would agree with that. We think there are other panels making similar types of decisions involved in families and medical care, such as guardianships at the administration tribunal. We believe that medical input into that would be critical in terms of the reports, but also a medical practitioner sitting on that kind of panel would be appropriate so those reports can be interpreted, because obviously there is a lot of jargon in medical language that is not necessarily clear to lay people or legal people on a panel. The advantage of the panel is the structure and the—what is the word?—the clarity of decision-making and following processes that that would achieve rather than

two doctors. Doctors—I probably should not say this—are not that great at following externally imposed processes; they tend to be independent thinkers. We do not always do as we are told. I would have significant concerns if a system just relied on two individual doctors and that was the only safeguard. I think it would be done appropriately most of the time but there would be circumstances where either processes were not followed or reports were not made, and that is the experience in the Netherlands that up to 23 per cent, somewhere between 20 and 23 per cent of euthanasia is not being reported. When you look at why it is not being reported, it might just be that they did not want to fill in the piece of paper or they did not think it met the definition, but it could also be that maybe they did not follow the prescribed process, maybe the requirements had not been met and maybe they were trying to hide that. We would really like to avoid that and we think a panel—you would need to be careful to make sure that it does not mean it takes six months to make a decision; that would obviously be a big problem for those people wanting to access this service.

Mr J.E. McGRATH: So every application would have to go before a panel if this came in?

Dr KHORSHID: Yes, but remembering that if we had a restricted type of model that had less than one per cent of all deaths, you are only talking about a small number per year and I think a panel-type structure properly funded would be able to deal with that workload quite easily.

Mr J.E. McGRATH: You also said that the guidelines should be very restrictive. What would you say to those people who have come to us and given evidence and people with neurodegenerative conditions and they say, “My life is intolerable”?

Dr KHORSHID: These are very difficult discussions and there are people living not just with neurodegenerative conditions but with all sorts of conditions where their suffering is extreme and perceived as intolerable. The next step, though, of saying that therefore we need to provide you with an assisted death, that is probably where the separation comes because if you offer death to anybody who says that their suffering is intolerable—that is a very personal experience—then you are basically saying that we are offering medically assisted suicide to anybody and that is what some of the critics say is happening in the Netherlands. If you have a significant psychiatric illness or you might have osteoarthritis of your knees, hips, ankles, shoulders and elbows that could cause very significant suffering and so people living with chronic disease now have this option of medically assisted death or effectively suicide and as a reasonable way to treat those conditions.

The CHAIR: Let me just bring you back to the question, which was about neurodegenerative diseases.

Dr KHORSHID: The Victorian legislation gave a 12-month expected prognosis for neurodegenerative diseases so they recognise that the suffering towards the end of life is different for those conditions, and I think that is a reasonable step that they have taken. I will stick to my point that if you broaden it too much, you affect the treatment and the place in society of other people living with those conditions who do not perceive their suffering as intolerable. That is just a bit dangerous and maybe we have to say no to individuals in order to protect the broader society. We do that all the time in laws, do we not? We accept restrictions on our autonomy in order to protect everybody else.

Hon COLIN HOLT: This is a quick question and maybe a suggestion. I have heard you say now that advance healthcare directives are something that should be followed because they are legislated law, and you also said that doctors are fairly independent thinkers and sometimes ignore the processes that are put in place. I would say that it is fair to say that we have evidence here that says doctors have ignored advanced healthcare directives and, in fact, some organisations do not even agree with them and do not even discuss them with potential patients. I would say that is fair to say, which is a real dilemma. One of terms of reference is about advance healthcare directives in this

question. Maybe that is a symposium for the future for the AMA, but do you have any comment around that because from my viewpoint we have a whole range of views on statutory instruments that are meant to be followed versus individual decision-making that ignores it. Any thoughts?

Dr KHORSHID: Yes. I am interested that organisations said they do not believe in them, because they are law. I am not aware what organisations they would be. Certainly we have heard from members that not all of them fully understand what the hierarchy of decision-making is when advance healthcare directives are in place. We have also heard that they do not necessarily know that an advance health directive is in place and, therefore, treatments that are against that directive could be instituted in good faith without knowing they are. We do believe there is a big body of work around advance health directives. We do not think they are the complete answer because they are a snapshot of one point in time and very rigid. We think that family discussions are an important model. I would agree with you that if they are in place and there is a law, they should be followed. We have to think of what are the barriers to that. Some of those are communication, some of that is education and maybe the instruments themselves need to be looked at. I do not know about that. Certainly we have heard that we need to communicate these things better. They need to be flagged. One of the places where it is difficult to know whether they are in place is an emergency department when somebody is brought in by an ambulance. Their advance health directive might have said, “I do not want to be brought in by ambulance”, but they are brought in by ambulance anyway. How does the ambulance know? We need to look at technology that provide us with that and the suggestion was made at our recent council meeting that maybe people with advance health directives should wear a bracelet like a medical bracelet so that straightaway an ambulance officer knows, “Hey, we’ve got to look this up.” They can quickly look it up and it might say, “No; under no circumstances are you to take me to a hospital”, and that might improve the situation. But I do accept that more education of doctors is required as well, and in the community. I think, there are not that many of these in place from what we understand.

The other point I guess is that we know that cannot be made once you have lost capacity and for a lot of people at the end of life, particularly living with dementia, it would be really appropriate for something to be in place but unfortunately it cannot be because they do not have capacity. We are just making sure that families and individuals know to start these discussions early whilst there is still capacity and then we can avoid unnecessary treatment and unnecessary suffering.

Hon NICK GOIRAN: I have two questions, since we are running out time. One is to take you back to the dialogue between you and the Chair around capacity and consent and terminal sedation. Terminal sedation is a technique used rarely in WA at the end of life. Terminal sedation itself does not kill the patient but it sedates the patient during the terminal phase. There was a discussion that took place around capacity and consent and I am fully respecting the fact that you indicated that this is not your area of expertise so if you need to take this on notice to liaise with somebody within AMA who has practiced this, I am quite happy for that. I take it that the normal principles of informed consent must apply for this procedure as it would for any other medical procedure. If a person is unable to demonstrate capacity, the normal processes that you would invoke for any other medical treatment would apply to this one. There are no rules that allow for capacity or informed consent to be absent in this treatment, as there would in any other. It might mean there are substitute decision-makers involved, of course, but I want to get confirmation that the same principles for informed consent apply for this medical technique as any other technique.

Dr KHORSHID: The short answer to that is yes, it is exactly the same principles that normally apply. I am not able to tell you with any certainty whether there are circumstances where there is no substitute decision-maker available because obviously the unusual thing is that this is done in concert with family and there are substitute decision-makers and it is all fine and everyone is happy.

Are there ever circumstances where there is no substitute decision-maker and terminal sedation is conducted? I do not know. We could ask the question and take that on notice. I do not know whether we would get a clear answer but we can certainly look for it. But I think the other point to make is that a lot of consent is implied. When you start a treatment regime, which in this case is palliative care, you know that that treatment regime is designed to relieve your suffering until you die. It could be argued—this is just me speaking from first principles—that by consenting to the treatment plan of relieving my symptoms until I die, that may well include terminal sedation and those discussions may occur right at the very start while the patient still has capacity, but obviously it would be impossible to occur with the patient at the time it is instituted because they may have lost capacity at that stage. We do not document consent in a formal way for all medical interventions by any means. The majority of medical interventions have an implied consent because the patient comes seeking a treatment, the doctor makes a suggestion or an offer and the patient does it. They take the medication and agrees to it, so we do not document those formally. We document procedures formally because you are anaesthetised and you lose all your capacity and those are more formal. I recognise there is overlap between terminal sedation and anaesthesia but I think that it is probably not seen by palliative care physicians as an area that worries them.

Hon NICK GOIRAN: Last question. You mentioned in your evidence that the AMA found it helpful to have dialogue in person with those international experts rather than simply reading materials. Do you recommend that the committee take evidence from those experts?

Dr KHORSHID: We do. We found their input on both sides of the debate very powerful and being able to have a two-way discussion as you do with all your witnesses is much more informing than reading documents. If you are able to attract them, we were able to attract two very interesting speakers to come all the way from the UK and Halifax in Nova Scotia for our symposium, it may be possible to attract people to come here or, of course, for a group to visit those countries that have been living with assisted dying laws for up to 20 years.

Hon ROBIN CHAPPLE: Going back to that very point my colleague has just raised, you had your symposium. The symposium was based around your current policy and it was to discuss the issues that the committee is looking at. You invited a number of people to come and make a presentation. You will provide that list you have of those people. Were any of the people who provided information supportive of voluntary euthanasia? How did you invite them?

Dr KHORSHID: Yes, they were supportive. A majority of the international speakers were supportive. The Canadians—Dr Gubitz, Dr Jocelyn Downie and Dr Jeff Blackmer—were all supportive.

Hon ROBIN CHAPPLE: Supportive of?

Dr KHORSHID: Voluntary euthanasia. It is fair to say that Professor Finlay and Professor Boer are not supportive, although Professor Boer has explained to us that he had gone on a journey. So we were seeking a balanced view. How we found them is that we basically decided that we were going to have a symposium and we wanted expert views, so we tasked Dr Noonan to go and find some experts for us. She was able to do research, talk to people and communicate with them by email and get a sense of who they were and what they could add, and then invited them.

Hon ROBIN CHAPPLE: As a result of that you have indicated that there was about a 50–50 split in your membership?

Dr KHORSHID: No, what I indicated was that the people who attended the symposium before we started the discussion were reasonably evenly split in their views. They are a small subset of our members and an even smaller subset of the medical profession. It was by no means an audience dominated by either pro or anti-euthanasia people; there was an even mix of views.

The CHAIR: Thank you for your evidence before the committee today. It has been a long session and we really appreciate your input to the inquiry. A transcript of this hearing will be forwarded to you for correction of transcribing errors only. 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.

Thank you for your evidence. We appreciate you taking the time to talk to us. We will write to you with any questions taken on notice, but I do want to reiterate my thanks for you taking the time to give evidence today, but also to speak to your membership before you did. It was a really constructive piece of evidence for us to consider. We appreciate that.

Hearing concluded at 12.02 pm
